NORC at the University of Chicago

FINAL REPORT

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Technical Report of The Maryland Telehealth Study

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Executive Summary

The COVID-19 nationwide public health emergency (PHE) declared in 2020 set the stage for the rapid expansion of telehealth for both somatic (physical) and behavioral health care services nationally and in Maryland. In the fall of 2020, the Maryland Health Care Commission (MHCC) convened a Telehealth Policy Workgroup consisting of about 70 diverse stakeholders who examined changes in telehealth policies that were made in response to the COVID-19 PHE. Along with focusing on which telehealth policies to extend beyond the PHE, the workgroup recommended that MHCC study the quality and cost of telehealth and its impact on access to care, alignment with new models of care, and consumer and provider satisfaction.

The Technical Report of the Maryland Telehealth Study, prepared under contract with MHCC, provides detailed results of the study examining the use of audio-only and audio-visual technologies in somatic (physical) and behavioral health care interventions. The mixed-method research study included a literature review, consumer interviews, a provider survey, behavioral health focus groups, and claims analyses.

The Maryland Telehealth Study findings presented in this report inform recommendations—provided in a separate report—on telehealth coverage and payment policy in Maryland that will be submitted to the Senate Finance Committee and House Health and Government Operations Committee, in accordance with § 2-1257 of the State Government Article.

Below are the study's key findings pertaining to access, utilization, and cost of telehealth services. These findings are discussed in more depth in the report.

Access

- Maryland consumer interviewees described telehealth's advantages, including convenience, agency in choosing a provider, and protecting privacy, particularly for behavioral health care.
- Maryland consumer interviewees and provider survey respondents would like telehealth services to continue, including audio-only and audio-visual technology options. Although both consumers and providers preferred audio-visual visits for somatic care, audio-only options support access when technical issues occur.
- Maryland consumers found that audio-only and audio-visual technologies mitigated access to care barriers including transportation costs, wait times, rurality, and mobility.
- The majority of consumer interviewees and provider survey respondents preferred audio-visual to audio-only telehealth services, citing better patient-provider communication as an advantage.
- Audio-only technology is a beneficial modality for some populations, such as those who lack access to the internet and smartphones.
- Audio-only technology was preferred by some consumer interviewees for behavioral health care, particularly for discussions of sensitive topics.
- Behavioral health care focus group participants strongly recommended including the option of audio-only technology while generally stating a preference for audio-visual technology.

Utilization

- Telehealth utilization was lower among individuals living in rural areas than individuals living in urban areas.
- Telehealth utilization was lower among older individuals than younger individuals.
- Approximately two-thirds of Maryland somatic care providers surveyed reported that patients with limited English language proficiency are less likely to use telehealth.
- In Medicaid claims, audio-visual telehealth services were used more than audio-only telehealth services for somatic and behavioral health care.
- Provider survey respondents recommended payment parity for telehealth and in-person care as the fixed costs of providing telehealth and in-person care are comparable.
- Maryland provider survey respondents cited low or inadequate reimbursement as the most likely reason they would discontinue offering telehealth services.
- Maryland consumer interviewees believed telehealth reduces their costs to access care, such as transportation and childcare.
- Across payors, the proportion of telehealth services relative to all services peaked early in the public health emergency (April 2020).
- Additional data collection and analyses are needed to assess audio-only and audio-visual technologies.

Cost

- Maryland consumer interviewees and provider survey respondents believed the convenience of telehealth reduces cost and may reduce urgent care and Emergency Room visits.
- Maryland behavioral health care providers supported payment parity of audio-only and audio-visual telehealth services for behavioral health care. This is consistent with the Centers for Medicare & Medicaid Services policy.
- Maryland consumer interviewees and provider survey respondents reported a lack of clarity regarding what telehealth services are covered and reimbursed.
- Additional data collection and analyses are needed to assess audio-only and audio-visual technologies' cost-effectiveness and quality.

Overall, consumers and providers would like to maintain access to telehealth services as a compliment to in-person care, acknowledging that audio-visual telehealth technology was preferred over audio-only technology. Consumers, providers, and behavioral health focus group participants also recognized that coverage and reimbursement for telehealth technologies will need to be adequate to maintain access to telehealth services.

This study's findings informed MHCC's development of seven telehealth recommendations pertaining to telehealth coverage, technology, and continuing payment levels for 24 months. MHCC also recommends leveraging the additional 24 months of telehealth coverage to conduct a robust study of Maryland's telehealth experiences to examine payment parity for audio-only and audio-visual technologies, cost-effectiveness, quality, and whether telehealth advances health equity. Study findings will inform the 2025 Maryland General Assembly as it considers the path forward for Maryland's telehealth policies.

Introduction

About this Report

The Technical Report of the Maryland Telehealth Study provides detailed results of the Commission's study examining the use of audio-only and audio-visual technologies in somatic (physical) and behavioral health care interventions. This report on the impact of telehealth services was prepared under contract with the Maryland Health Care Commission (MHCC).

The Preserve Telehealth Access Act of 2021[1] specified research questions related to access to care and utilization of telehealth, and the impact on the cost and quality of health care in Maryland. A detailed list of research questions guiding the MHCC telehealth study is in Appendix A. Generally, the research questions explore themes across telehealth's impact on access to care, utilization, and cost.

The Maryland Telehealth Study findings presented in this report inform recommendations—provided in a separate report—on telehealth coverage and payment policy in Maryland that are submitted to the Senate Finance Committee and House Health and Government Operations Committee in accordance with § 2-1257 of the State Government Article.

This Technical Report includes two types of information: 1) primary data—qualitative and quantitative data collected and analyzed for the Maryland Telehealth Study, including a provider survey, consumer interviews, and behavioral health care organization focus groups; and 2) secondary data—compiling evidence from a literature review and an analysis of health care claims from commercial payers, Medicaid, and Medicare.[2]

Expansion of Telehealth During the COVID-19 Pandemic

The COVID-19 public health emergency (PHE) declared in 2020 set the stage for the rapid expansion of telehealth for both somatic (physical) and behavioral health care services nationally and in Maryland. On March 13, 2020, the Trump Administration declared a PHE[3] that allowed the U.S. Secretary of Health and Human Services (HHS) to enact section 1135 of the Social Security Act.[4] This allowed the Centers for Medicare & Medicaid Services (CMS) to grant Medicare, Medicaid, and the Children's

[1] The Preserve Access to Telehealth Act Chapter 70 (House Bill 123) and Chapter 71 (Senate Bill 3) of the 2021 Laws of Maryland, Preserve Telehealth Access Act of 2021

[2] The study used a combination of peer-reviewed and the more recent gray literature such as issue briefs and data snapshots to capture the most current and relevant literature on the delivery of telehealth and payment for telehealth services.

[3] In response to the COVID pandemic, Maryland Gov. Larry Hogan issued a state of emergency on March 5, 2020.

[4] Social Security Act, Section 1135, Authorization to Waive Requirements During National Emergencies, www.ssa.gov/OP_Home/ssact/title11/1135.htm

Health Insurance Program (CHIP) greater flexibility for covering telehealth services.[5] CMS granted section 1135 waivers to states allowing expanded telehealth coverage and removing restrictions that previously limited telehealth services based on geographic location. These coverage expansions allowed physicians and non-physician practitioners to obtain payments equivalent to in-person for telehealth visits.[6] Additional provisions permitted Medicare to pay for telehealth services provided in clinics, hospitals, and other health care settings, such as nursing homes and patients' homes. Previously, telehealth services were limited to rural Medicare fee-for-service (FFS) beneficiaries receiving telehealth services at an eligible health care site, such as a designated rural clinic or hospital.[7]

By one estimate, U.S. telehealth use increased by more than 3,000 percent in 2020 compared to 2019 as providers and patients substituted telehealth for in-person visits for both somatic and behavioral health care services.[8] Over the pandemic, telehealth use has ebbed and flowed as COVID cases receded and surged, in tandem with restrictions on in-person visits, but experts predict that continued demand for telehealth will provide opportunities to change health care delivery and financing going forward.[9]

Background: The Preserve Telehealth Access Act of 2021

In the fall of 2020, MHCC convened a Telehealth Policy Workgroup consisting of about 70 diverse stakeholders who examined changes in telehealth policies that were made in response to the COVID-19 PHE. Along with focusing on which telehealth policies to extend beyond the PHE, the workgroup recommended that MHCC study the quality and cost of telehealth and its impact on access to care, alignment with new models of care, and consumer and provider satisfaction.

Subsequently, during the 2021 legislative session, the Maryland General Assembly passed the Preserve Telehealth Access Act of 2021,[10] which Gov. Larry Hogan signed on April 13, 2021. The law (House Bill 123 and Senate Bill 3) temporarily expanded telehealth coverage and payment, including the following changes:

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[5] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers Factsheet, Centers for Medicare & Medicaid Services, www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

[6] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers Factsheet, Centers for Medicare & Medicaid Services, www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

[7] Ibid.

[8] Telehealth Claim Lines Increase 3,060 Percent Nationally When Comparing October 2019 to October 2020. FairHealth. 2021. www.fairhealth.org/press-release/telehealth-claim-lines-increase-3-060-percent-nationally-when-comparing-october-2019-to-october-2020

[9] Kaufman Hall, A New Approach to Telehealth Strategy: Planning for the Pandemic and Beyond. Available at: www.kaufmanhall.com/ideas-resources/article/new-approach-telehealth-strategy-planning-pandemic-and-beyond.

[10] The Preserve Access to Telehealth Act Chapter 70 (House Bill 123) and Chapter 71 (Senate Bill 3) of the 2021 Laws of Maryland, Preserve Telehealth Access Act of 2021

1) The definition of telehealth was revised for the period spanning July 1, 2021, to June 30, 2023, to cover an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service;
2) Insurance coverage should be provided regardless of the location of the patient;
3) Health insurers must provide reimbursement for a health care service appropriately provided through telehealth on the same basis and at the same rate as if the services were delivered in person; and
4) Insurers are required to cover either in-person or telehealth behavioral health care services. Coverage was extended to treatment and counseling for substance use disorders and mental health conditions.

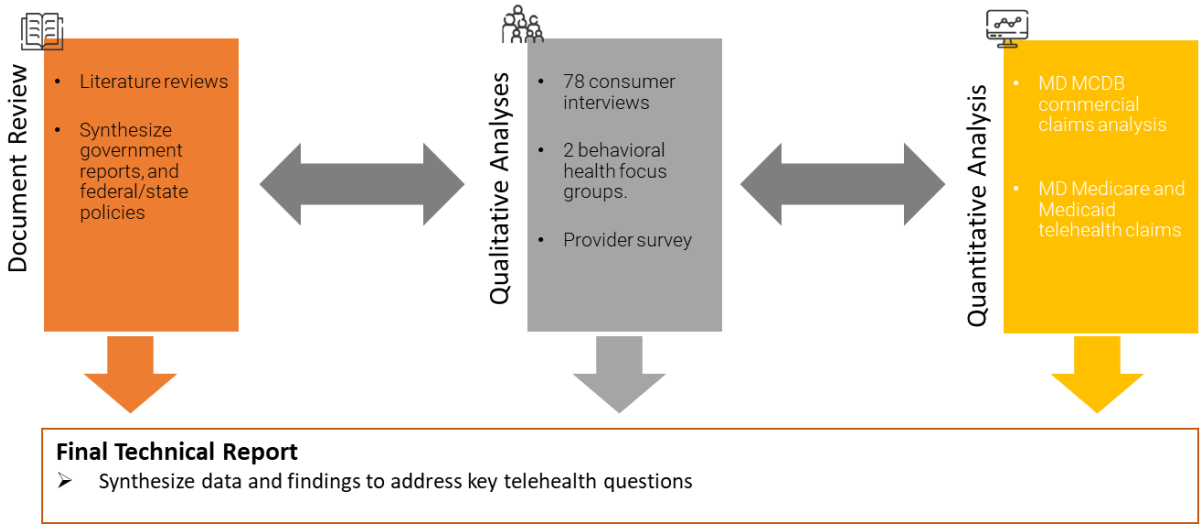
The law also charged MHCC, in consultation with the Maryland Insurance Administration, with preparing and submitting a report on the impact of providing telehealth services in accordance with the Act's requirements, including the use of audio-only and audio-visual technologies in somatic and behavioral health care interventions. The report is to include (1) specified analyses; (2) a study of the alignment of telehealth with new models of care; (3) an assessment of the efficiency and effectiveness of telehealth services and in-person services (including a survey of health care providers); (4) an assessment of patient awareness of and satisfaction with telehealth coverage; (5) specified reviews of the appropriateness of telehealth across the continuum of care, the inclusion of clinic hospital fees in telehealth reimbursement, and the use of telehealth to satisfy network access standards; and (6) study or analysis of any other issues identified by MHCC.[11]

Summary of Approach and Limitations

NORC conducted a mixed-methods study that included both quantitative and qualitative primary and secondary data on telehealth. The research considers both audio-only and audio-visual technologies relative to in-person care for somatic and behavioral health care interventions.

[11] Maryland General Assembly, Department of Legislative Services, Fiscal and Policy Note, Senate Bill 3, mgaleg.maryland.gov/2021RS/fnotes/bil_0003/sb0003.pdf

Exhibit 1. Mixed Methods Approach



Literature Review

NORC screened over 2,000 articles of evidence on access, utilization, and cost of telehealth to identify and compile existing evidence on audio-only and audio-visual telehealth services as a mechanism for delivering somatic and behavioral health care in lieu of in-person somatic or behavioral health care services. The review included 259 peer-reviewed and gray literature articles. The initial review was conducted between December 2021 and February 2022. As telehealth use was an emerging topic during the PHE with the ongoing publication of telehealth research, the initial literature review was updated with an e-scan of gray and peer-reviewed literature between April 2022 and June 2022.

Consumer Interviews

NORC conducted 78 semi-structured 30-minute telephone interviews with users and non-users of telehealth services across Maryland. During the data collection period, saturation, or when the interviews stopped yielding new information, was reached after 30 of the 78 initial interviews. The consumer interviews explored their experiences and perceptions regarding access to and use of audio-only and audio-visual telehealth technologies. NORC selected consumers to achieve regional-level representation across key demographic characteristics including age, sex, race and ethnicity, region (Baltimore City, Eastern Shore, Montgomery and Prince George's County, and Western Maryland), income, education level, insurance coverage, and language spoken (English and Spanish).

Provider and Consumer Organization Behavioral Health Care Focus Groups

NORC conducted two one-hour virtual behavioral health care focus groups with provider and consumer organizations. MHCC provided NORC with a list of eight provider organizations and 12 consumer organizations that were invited to participate in the focus groups. Six participants from each

organization type participated in the focus groups. The focus groups explored experiences and perceptions of access and utilization of audio-only and audio-visual telehealth technologies.

Provider Survey

NORC fielded a web-based survey to eligible providers from March 1, 2022, to April 29, 2022 resulting in 1,083 respondents. The eligible target population included all somatic care providers engaged in primary care delivery and behavioral health care providers with a practice location in Maryland. Eligibility was determined through the registration of valid National Provider Identification (NPI) number and verified through the online National Provider Registry. In collaboration with MHCC, NORC assigned providers to one of four geographic regions: (1) Eastern Shore Region, (2) Western Maryland Region, (3) Montgomery County and Prince George's County, and (4) Central/Southern Maryland Region. All providers meeting the eligibility criteria (somatic care providers engaged in primary care delivery and behavioral health care providers with a practice location in Maryland) were able to enter their NPI on the landing page to access the online survey.

Claims Analysis

NORC conducted an analysis of Medicare, Medicaid, and commercial health care claims data from Maryland's All-Payer Claims Database (APCD). The claims analyses explored trends in telehealth use from 2018 through 2021 for Medicaid and commercial health care claims and 2018 through 2020 for Medicare claims across several key aspects of health care services, including the comparison of cost and service utilization for telehealth and in-person services.

Limitations

As part of NORC's mixed methods approach, we conducted stakeholder interviews with consumers. We convened targeted provider and consumer organization behavioral health care focus groups that ensured multiple perspectives were collected to meet the MHCC's objectives. We gathered additional insight through literature reviews that highlighted the national narrative and Maryland's telehealth utilization landscape through claims analyses.

The study has some limitations. First, the results gleaned from some of the study activities may not be generalizable. While providing important perspectives on telehealth in Maryland, the consumer interviews and behavioral health focus groups are limited by the smaller numbers intrinsic to qualitative research with primary data. The behavioral health care focus group and provider survey did not use random sampling. Therefore, potential bias in responses is present.

Given the relative recency of the start of the PHE, there is limited peer-reviewed literature on telehealth provided after March 2020. As a result, much of the peer-reviewed and gray literature was published before the PHE and does not reflect the expansion of telehealth services during the PHE, such as changes in utilization and reimbursement policies.

There were also several limitations to conducting claims data analyses, which precluded NORC from being able to draw more definitive conclusions.

In general, claims provide insight into services provided and paid for during calendar years 2018 and 2021; the claims analysis does not provide insight into how claims were billed and processed (including if a telehealth service was mis-billed as in-person or vice versa), or how the process of provider coding and payer processing changed over time.

- The claims analysis is limited to only evaluation and management (E&M) services as defined by the Restructured Berenson-Eggers Type of Service Classification System (RBCS). The analyses do not reflect telehealth usage and trends outside of identified E&M services.
- We were unable to conduct meaningful race/ethnicity-stratified analysis, given that the race/ethnicity was "Unknown" in 68% of commercial claims and 29% of Medicaid claims.
- The majority of commercial telehealth codes (60% of 2020 claims and 57% of 2021 claims) and many Medicare telehealth codes do not distinguish between audio-only and audio-visual modes. Rather, most payers allowed providers to use generic codes for billing telehealth services, which limited our ability to conduct an in-depth comparative analysis between services delivered via audio-only versus those delivered via audio-visual technologies. See Appendix F for distribution of telehealth modalities across payers.
- The telehealth expansion was implemented in March 2020 in response to the COVID-19 PHE, which was a large disruptor to the health care system and to beneficiary health-seeking behaviors. For example, we observed substantial and differential declines in total E&M service utilization across beneficiary demographic subgroups during the early months of the pandemic. As such, the drivers of telehealth utilization during the pandemic may be very different from the expected drivers of telehealth utilization in the absence of a pandemic.
- NORC was unable to obtain access to individual Medicare claims given MHCC's data use agreement. NORC received access to high-level summary data for Medicare that limited our ability to conduct significance testing both within Medicare beneficiaries and across beneficiaries covered by different payers (Medicare vs. commercial vs. Medicaid).
- NORC was unable to include 2021 Medicare claims in the analysis due to stark discontinuities in service utilization trends between December 2020 and January 2021. The observed data discontinuity is likely due to cell size suppression in the 2021 summary data we received. As a result, it is challenging to interpret 2021 utilization trends because it is unclear how much of the observed changes in trends are attributed to data limitations versus a reflection of true differences in underlying trends.
- Commercial and Medicaid claims were made available through the end of 2021, while Medicare claims were available through the end of 2020. Relative to the expansion of telehealth implemented in March 2020, there is a short period of follow-up time. It is also unclear whether we have reached a "post"-intervention/pandemic period. It is likely that health care-seeking behaviors – including those via telehealth – are still changing in response to COVID-related

reasons. Thus, it is impossible to confidently attribute short-term cost or utilization outcomes to telehealth or to examine longer term outcomes.

Telehealth Landscape Prior to COVID-19

The pre-COVID telehealth landscape was fragmented, with payors—Medicare, Medicaid, and commercial insurers—offering consumers limited and varied telehealth options. Nationally, rural fee-for-service (FFS) Medicare beneficiaries had limited access to telehealth services for psychiatry, counseling, the management of chronic conditions, and some follow-up services in a hospital or nursing home. They could receive a telehealth consult from a "distant site" provider, such as a specialist located at a tertiary medical center, but were restricted to accessing the telehealth consultation at a designated rural health care site ("originating site"), such as a rural health clinic.[12]

Although all states had policies in place that required Medicaid reimbursement for audio-visual telehealth, state policies differed with reimbursement restrictions on the types of services covered, the types of provider delivering the service, the geographic location of the beneficiary or originating site (19 states allowed services in the patient's home), and whether there was reimbursement parity with similar in-person services.[13] Forty-three states have telehealth commercial insurance laws that vary across what services are covered.[14] While 21 states, including Maryland's temporary payment parity, have adopted payment parity for telehealth and in-person services, 29 states and the District of Columbia do not require payment parity.[15] Many consumers had access to various telehealth services from primary care and specialty care providers, behavioral health care practitioners, and remote patient monitoring.

Before the PHE, the evidence base for telehealth's effectiveness was limited because of the slow adoption of telehealth by providers and consumers, in part due to policy and payment variation and complexities across payors. However, the rapid growth of telehealth services during the PHE has created a quasi-natural experiment and opportunities to study and evaluate the impact of telehealth on health care access, utilization, quality, and costs. As a result, we anticipate a growing body of robust research literature related to telehealth that will help to inform future telehealth policies.

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[12] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers Factsheet, Centers for Medicare & Medicaid Services, www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

[13] Providing Outpatient Telehealth Services in the United States Before and During Coronavirus Disease. Joshua J. Brotman, MD, Robert M. Kotloff, MD. 4: American College of Chest Physicians CHEST Reviews, 2021, Vol. 159. doi.org/10.1016/J.CHEST.2020.11.020

[14] State Telehealth Laws and Reimbursement Policies Report. Center for Connected Health Policy Spring 2022 www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-spring-2022/

[15] Ibid

Technical Results by Study Activity and Key Findings by Theme

Access to Care

This section describes findings related to Maryland residents' access to care, including timely access to providers and services, insurance coverage, and affordability; how audio-only and audio-visual telehealth affected access to somatic and behavioral health care; patient and provider experience and satisfaction with telehealth; and the potential impact telehealth has on health disparities, particularly for underserved populations (e.g., racial and ethnic minorities, people living in rural communities, people with low incomes and/or who lack access to Internet/broadband). Findings are organized by study activity and include results from the literature review, consumer interviews, behavioral health focus groups, and provider survey.

Access to Care: Literature Review Findings

After the PHE began, temporary federal and state telehealth policy flexibilities to use audio-visual and audio-only telehealth services with minimal restrictions and payment parity served as a tipping point for rapid and wide telehealth growth during the PHE.

Emerging evidence from the PHE indicates that integrating audio-only and audio-visual telehealth modalities into the delivery system increased patient access to timely care, earned high patient satisfaction marks, and contributed to positive patient outcomes.[16] A study conducted at the University of Southern California Keck Medical Center surveyed internal medicine patients aged 18 years and older who completed a telemedicine visit between March 10 and April 17 2020.[17] Survey measures included patient demographics, degree of interpersonal trust in patient-physician relationships (using the Trust in Physician Scale), and visit-related concerns. Of 1,624 telemedicine services conducted during this period, 368 (22.7%) patients participated in the survey. Across the study, respondents were very satisfied (173/365, 47.4%) or satisfied (n=129, 35.3%) with their telemedicine visit.

Research indicates that providers generally are satisfied with telehealth and are open to conducting virtual services after the PHE ends. Volcy and team surveyed internal medicine and family medicine providers at an academic safety net institution and found that more than 90 percent agreed or strongly

[16] Eugene S. Farley, Jr. Health Policy Center. The Impact of Telemedicine Policy Changes on Health First Colorado Utilization and Costs. Prepared for the Colorado Department of Health Care Policy and Financing. June 2021. medschool.cuanschutz.edu/docs/librariesprovider231/default-document-library/telemedicine-report-2021.pdf?sfvrsn=6afbc8ba_0

[17] Orrange, S., Patel, A., Mack, W. J., & Cassetta, J. (2021). Patient Satisfaction and Trust in Telemedicine During the COVID-19 Pandemic: Retrospective Observational Study. JMIR human factors, 8(2), e28589. doi.org/10.2196/28589

agreed that they would be amenable to providing telehealth after the pandemic and felt comfortable managing services virtually.[18]

Select Literature on Telehealth and Access to Care

The selected articles described below provide evidence that access to care through telehealth for diverse populations maintains patient satisfaction for somatic and behavioral health care. The featured articles address patient-centered care and comparisons between telehealth and in-person care and reflect the primary themes for the broader literature review.

Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review[19].

This literature review examined telehealth interventions in rural areas for mental health, HIV, reproductive care/women's health, orthopedics, osteoporosis, acute ischemic stroke, substance use disorder, ophthalmology, and emergency medicine through studies published from 2017 – 2020. Key takeaways:

- Telehealth interventions across specialties improved access and efficiency by decreasing time and indirect costs for travel.
- Telehealth users in rural communities had positive experiences and were highly satisfied.
- Telehealth increased health education.
- Telehealth improved provider retention.

Health Care Providers' and Professionals' Experiences with Telehealth Oncology Implementation During the COVID-19 Pandemic: A Qualitative Study[20].

A qualitative study of telehealth for patients with cancer during COVID included interviews with oncology care providers, physicians, social workers, psychologists, dieticians, and pharmacists. Questions addressed communication, patient engagement, and care coordination. Key takeaways:

- Providers reported that integration of telehealth in oncology care allowed for better care coordination among different specialties where the team of specialists discussed treatment programs.

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[18] Volcy J, Smith W, Mills K, Peterson A, Kene-Ewulu I, McNair M, Kelsey R, Mbaezue N. Assessment of Patient and Provider Satisfaction With the Change to Telehealth From In-Person Visits at an Academic Safety Net Institution During the COVID-19 Pandemic. J Am Board Fam Med. 2021 Feb;34(Suppl):S71-S76 doi.org/10.3122/jabfm.2021.s1.200393

[19] Butzner M, Cuffee Y. Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review. J Med Internet Res. 2021 Aug 26;23(8):e29575. doi: https://doi.org/10.2196/29575.

[20] Turner K, Bobonis Babilonia M, Naso C, Nguyen O, Gonzalez BD, Oswald LB, Robinson E, Elston Lafata J, Ferguson RJ, Alishahi Tabriz A, Patel KB, Hallanger-Johnson J, Aldawoodi N, Hong YR, Jim HSL, Spiess PE. Health Care Providers' and Professionals' Experiences With Telehealth Oncology Implementation During the COVID-19 Pandemic: A Qualitative Study. J Med Internet Res. 2022 Jan 19;24(1):e29635. doi: https://doi.org/10.2196/29635.

- Telehealth could be used to enhance in-person visits between patients, providers, and caregivers.
- Audio-only and audio-visual telehealth can pose challenges for effective communication between providers and patients.
- Providers reported that patient engagement was challenging, and providers felt they could not fully respond to patients' emotions remotely.

Patient Satisfaction and Trust in Telemedicine During the COVID-19 Pandemic: Retrospective Observational Study[21].

An academic medical center in Los Angeles surveyed patients on their telehealth experience during the first few months of the PHE. Key takeaways:

- Almost half (47%) of patients surveyed were very satisfied and another 35% of patients were satisfied.
- Physician trust was associated with satisfaction with telehealth.
- Visit related factors associated with satisfaction included the lack of technical issues, less concern over visit privacy and visit cost, and convenience.

Learning From COVID-19- Related Flexibilities Moving Toward More Person-Centered Medicare and Medicaid Programs[22].

This white paper explored the impact of Medicare telehealth flexibilities during the PHE. It reports on existing quantitative and qualitative studies. Key takeaways:

- Telehealth flexibility improves access to care.
- Telehealth helped behavioral health care patients covered by Medicare continue to access care from their providers during the PHE.
- Telehealth and telehealth policies impacted health disparities and certain vulnerable populations.

Factors Associated with Use of and Satisfaction with Telehealth by Adults in Rural Virginia During the COVID-19 Pandemic[23].

This study included a survey to assess the use of and satisfaction with telehealth services during the pandemic in a predominantly rural sample from Virginia. Survey findings estimated the magnitude of the association between demographic and health characteristics, health literacy, internet access, and the odds of using telehealth. Key takeaways:

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[21] Orrange S, Patel A, Mack WJ, Cassetta J. Patient Satisfaction and Trust in Telemedicine During the COVID-19 Pandemic: Retrospective Observational Study. JMIR Hum Factors. 2021 Apr 22;8(2):e28589. doi: https://doi.org/10.2196/28589.

[22] Anthony, Stephanie, Mann, Cindy, Siao Tick Chong, Michael. Learning From COVID-19- Related Flexibilities Moving Toward More Person-Centered Medicare and Medicaid Programs. Manatt Health and Health Management Associates. 2022 March. https://www.manatt.com/insights/newsletters/health-highlights/covid-19-related-flexibilities-moving-toward-more.

[23] Thomson MD, Mariani AC, Williams AR, Sutton AL, Sheppard VB. Factors Associated With Use of and Satisfaction With Telehealth by Adults in Rural Virginia During the COVID-19 Pandemic. JAMA Netw Open. 2021 Aug 2;4(8):e2119530. doi: https://doi.org/10.1001/jamanetworkopen.2021.19530.

- About three out of four respondents (78%) who used telehealth felt comfortable communicating with clinicians using telehealth and 79% of this same group shared that they would use telehealth again.
- Over two-thirds of telehealth users (68%) found telehealth to be an acceptable mode of health care delivery.
- Higher patient satisfaction was associated with reliable access to the internet and high levels of health literacy.

Select Literature on Audio-only Telehealth vs. Audio-visual Telehealth

A range of studies have examined the impact of audio-only telehealth during the PHE. Audio-only telehealth plays a key role in the delivery of treatment for substance and opioid use disorders with medication

Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic[24]*.*

This retrospective review of outpatient encounters across all specialties at the University of Michigan Health System was conducted using data from April 2020 to June 2020 to determine the factors associated with patients opting to use audio-only or audio-visual telehealth. Key takeaways:

- A total of 104,204 patients had at least one telehealth visit and 45.4% received care through audio-only visits.
- Patient characteristics associated with lower probability of using audio-video visits included: older age, African American, needed an interpreter, Medicaid as primary insurance, and lived in a zip code with low broadband access.
- Barriers to telehealth included: limited access to technology, lack of technology literacy, inadequate support and decreased digital access based on income and geography.

State Policy Changes Could Increase Access to Opioid Treatment via Telehealth[25]*.*

The PEW Charitable Trust report explored the benefits of using telehealth to treat opioid use disorder (OUD) and included federal and state policy recommendations to address policy and social barriers to telehealth. Key takeaways:

- Recommended public and private insurers reimburse all OUD treatment providers and services delivered via telehealth, including prescribing buprenorphine and other medication treatments.

[24]Chen J, Li KY, Andino J, Hill CE, Ng S, Steppe E, Ellimoottil C. Predictors of Audio-Only Versus Video Telehealth Visits During the COVID-19 Pandemic. J Gen Intern Med. 2022 Apr;37(5):1138-1144. doi: https://doi.org/10.1007/s11606-021-07172-y. Epub 2021 Nov 17. PMID: 34791589; PMCID: PMC8597874.

[25] Doyle S. State Policy Changes Could Increase Access to Opioid Treatment via Telehealth. PEW; 2021. doi: https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth?fbclid=IwAR3q3vafuw5gcLGX7g9dghM5WHpPNjPYadeT99T2g1pZpZwAHHaZmqHoEOI.

- Noted a study conducted in rural Maryland where an OUD program delivered via telehealth reported retention and cessation outcomes comparable to in-person programs.
- Recommended allowing audio-only OUD treatment services for patients with Medicaid.
- Recommended that telehealth-delivered OUD services should be reimbursed at in-person rates.

Further research is needed to assess the quality of audio-only telehealth visits compared to audio-visual telehealth visits.

Access to Care: Consumer Interview Findings

Consumer interviewees across demographic groups reported that telehealth maintained and expanded their access to care during the PHE. At the onset of the pandemic, telehealth offered consumer interviewees the ability to maintain access to health care services when in-person care was unsafe. As in-person care became safer, consumers reported continuing to receive care via telehealth due to the relative availability of appointments and the convenience of receiving virtual care, such as saving the time and cost of traveling to an in-person appointment. Additionally, some consumers who received telehealth services described feeling “more heard” by their providers. Consumers also reported feeling that their providers were more attentive to what they were saying when receiving care via telehealth as the provider could not rely primarily on a physical exam. This perception of patient-centered care was present in both audio-only and audio-visual telehealth services.

Behavioral Health Care Consumers described feeling that they had more agency over their behavioral health care when they sought care via telehealth. Consumers had more control over when and from whom they received care when seeking care via telehealth, with it being easier to "shop around" for a provider with whom they felt comfortable. However, one consumer described their providers as more committed to their care when delivered in-person rather than via telehealth.

Telehealth decreased the stigma associated with seeking and receiving behavioral health care. Consumers reported that seeking behavioral health care services via telehealth reduced their privacy concerns. Consumers described not being concerned about encountering a neighbor or colleague at a behavioral health care provider's office as had been the case prior to using telehealth. Most consumers felt comfortable seeking care from their homes. However, some consumers described concerns about privacy, such as other household members being able to listen to the telehealth visit.

Audio-Only & Audio-Visual Telehealth for Somatic and Behavioral Health Care Consumers predominantly expressed a preference for audio-visual telehealth services as it increased their feelings of connectedness by seeing providers' faces and nonverbal cues.

For somatic care, when asked about the differences between their experiences using audio-visual and audio-only telehealth, consumers noted that audio-visual telehealth enhanced communication with providers.

Consumers described communication challenges during audio-only telehealth services that contributed to a reluctance to tell the provider about medical concerns. Consumers noted the lack of facial expressions and seeing the provider made audio-only difficult. Consumers also stated that audio-only telehealth served as an important alternative communication when individuals could not reach their providers using audio-visual methods, enabling individuals to continue to access care despite complications with audio-visual technologies.

For behavioral health care services, consumers had mixed preferences regarding audio-visual versus audio-only services. Interviewees articulated that audio-only services were free from the technological and network access complications associated with audio-visual calls, helping some consumers in rural areas access telehealth more easily. Some consumers also preferred audio-only services to reduce stigma while other consumers preferred to see providers' facial expressions and body language through audio-visual services. These findings suggest the need for flexible telehealth options in the future.

Access to Telehealth by Geography According to consumers in rural Maryland, telehealth reduced geographic barriers to care. Several consumers in rural areas described finding it challenging to find primary and specialty care providers accepting new patients. Before the expansion of telehealth, these rural consumers were traveling long distances to seek initial and follow-up care, which was not always possible due to work and family obligations, mobility concerns, and weather.

Access to Telehealth Among Underserved Populations Historically underserved populations, including individuals with disabilities and non-English speakers, reported that telehealth improved their access to health care and did not create new barriers to care. Self-reported disabled consumers shared that telehealth alleviates difficulties accessing care related to mobility and transportation. All Maryland consumer interviewees whose primary language is Spanish received telehealth services from a provider with whom they had an existing relationship. These providers met their linguistic needs either through multilingual providers or the inclusion of certified translators.

While most consumers expressed openness to telehealth services and indicated they would consider scheduling telehealth services for future appointments, if available, some non-users expressed hesitations about scheduling telehealth services due to potential lack of insurance coverage.

Telehealth vs. In-Person Services Many consumers described the need for a hybrid model of care that combines telehealth and in-person care, giving patients the choice of in-person or telehealth services. Interviewees distinguished between care that required physical testing or interventions to be

delivered in-person, and care that could be delivered remotely, including follow-up services after a test or prescription refills.

While most consumers reported that telehealth increased their access to care, a few consumers expressed that even as the pandemic abated, they could not make appointments for in-person care. Several consumers described that when trying to make an appointment to see their provider, telehealth appointments were readily available, but in-person appointments were unavailable as providers were booked for weeks or months. As a result, to receive care as soon as they felt it was needed, many consumers used telehealth care, even if they preferred in-person care.

Role of Technology Maryland consumers identified technology as a pivotal factor in increasing access to telehealth and the overall quality of those services. Telehealth users reported that the easy-to-use virtual platforms increased satisfaction, facilitated telehealth use, and broadened access to their health care providers. Virtual platforms, coupled with consumers' prior technology utilization and navigation experience, were also associated with a better overall experience using telehealth. Consumers were more satisfied, and reported better quality, if they had prior technology experience with audio-visual technology (e.g., Zoom). Some consumers described challenges using different virtual platforms, such as requiring downloading new software or apps and unique account or login credentials. Consumers called for user-friendly telehealth options (e.g., Zoom, FaceTime), and one user recommended a universal platform to limit software and app installations from individual providers.

Impact of Telehealth on Follow-up Visits Some consumers described telehealth services that required an in-person follow-up services with potential negative consequences, such as delays in treatment and added out-of-pocket costs. One consumer described a telehealth experience that was not as comprehensive as in-person care and ultimately required an in-person visit. While the interviewee appreciated the opportunity to access care and treatment initially via telehealth, she highlighted a concern that certain forms of care could not be replaced by telehealth.

Access to Care: Behavioral Health Care Organizations' Focus Group Findings

Behavioral health care consumer and provider organizations valued health care delivery that accommodates in-person, audio-only, and audio-visual telehealth access. Although audio-visual technology was preferred by most consumers and providers, audio-only is necessary to foster access options for clients who may have limited incomes, experience homelessness, or lack access to broadband and/or technologies to support telehealth (e.g., smart phones and tablets).

Consumer & Provider Organization Choice Participants expressed a strong desire to maintain a choice of care modalities, including audio-only, audio-visual, and in-person visits. There was consensus that telehealth offered greater access to behavioral health care, fostering immediate access to patients in a crisis, reducing transportation barriers, improving ease of scheduling, and allowing increased flexibility for patients and providers. Provider organization participants further noted that telehealth decreased no-show rates and lapses in care for ongoing mental health treatment.

Audio-only & Audio-Visual Preference Participants articulated high levels of overall satisfaction with telehealth, noting that having the option of using audio-only or audio-visual technologies is essential to meeting patients where they are. This flexibility of telehealth technologies supports patient preference, fosters patient-centered care, addresses barriers to broadband access, and accommodates variations in access to telehealth technologies (e.g., smartphone, tablet, computer). Generally, provider organization participants preferred audio-visual because it increased engagement but strongly advocated audio-only as an important option for greater patient access.

Participants shared concerns regarding the continuity of access to telehealth options given the regulatory uncertainty, noting that some providers were hesitant to invest in technology if telehealth care is not going to be reimbursed in the future. While consumers and providers strongly advocated for choice, audio-visual technologies were noted to encourage a higher level of patient-provider engagement than audio-only technologies.

In-Person Care vs. Telehealth Participants' views on in-person care versus telehealth were mixed. While consumers and providers have similar levels of satisfaction and engagement, some focus group participants expressed concerns about the level of patient disengagement during telehealth services. Likewise, telehealth's flexibility was viewed an advantage, but some consumer organization participants shared privacy concerns and challenges for some medical conditions that may be incompatible with telehealth. Overall, participants conveyed that it is important to maintain the choice of care delivery that best addresses patients' needs.

Perception of Privacy between the Patient and Providers Participants conveyed privacy concerns for patients who rely on public internet, homeless populations, and those who live in unsafe conditions. Provider organizations advised that new privacy screening protocols were initiated to safeguard patient privacy. The screening protocols include questions about the patient's surroundings, safety, and educating patients about privacy when using telehealth. Overall, privacy was not a prohibitive factor for telehealth use and some consumer organization participants were less concerned with privacy than provider organization participants.

Access to Care: Provider Survey Findings

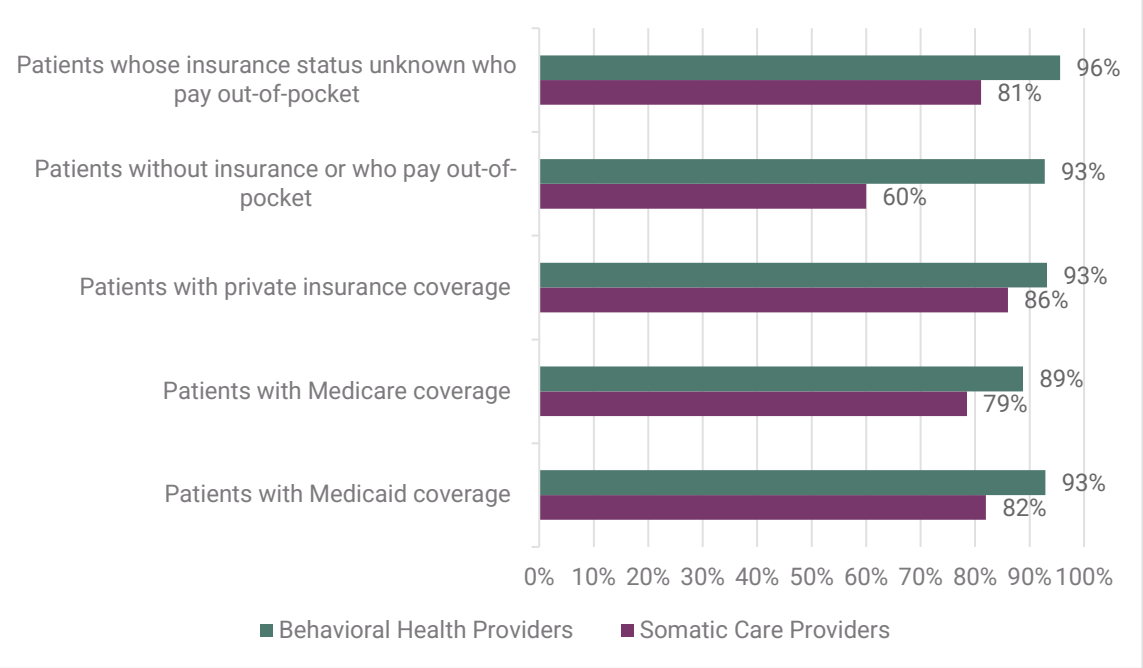
The majority of providers reported that they use both audio-only (86% of somatic care providers, 67% of behavioral health care providers) and audio-visual (94% somatic care, 98% behavioral health) telehealth services. Maryland provider respondents reported few instances of discontinuation or lack of audio-only adoption. Many providers also reported they would like to increase the use of telehealth in their practice. This sentiment was expressed more frequently by providers to increase audio-visual telehealth services (78% of somatic care providers, 85% of behavioral health care providers) compared to audio-only telehealth services (69% somatic care, 68% behavioral health).

Over 85 percent of somatic care providers and about 95 percent of behavioral health care providers noted that telehealth gives patients more access to care compared to in-person services. Nearly all

providers (more than 97%) thought both modes of telehealth improved patient access to health care services compared to not having telehealth. About one-third of patients or clients to whom telehealth services were provided were new patients, demonstrating that telehealth expanded access to new patients.

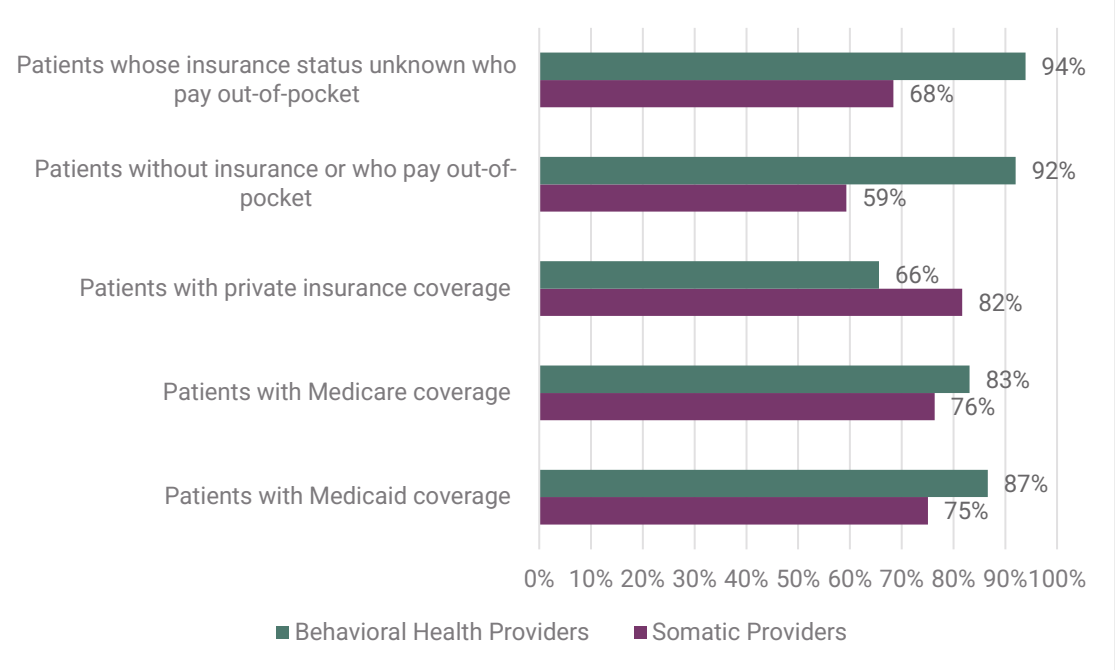
Patient Satisfaction The majority of clinicians indicated that more than 50 percent of their patients are satisfied with telehealth services delivered by both modalities, with slightly higher rates of favorability among their patients for audio-visual services compared to audio-only services, a finding that held across the five insurance categories (Exhibits 2 and 3). Providers reported that more than half of patients with all types of insurance and no insurance, have a favorable attitude for telehealth for somatic and behavioral health care, indicating they value this mode of accessing health care.

Exhibit 2. Percent of providers who reported at least 50% of their patients reacted favorably to audio-visual telehealth services



Note: For this question, only providers whose served client population was at least 10 percent of a given type were eligible to answer questions on favorability. This exhibit shows the different types of patient payment options that Somatic Care Providers and Behavioral Health Care Providers see and their preference for audio-visual telehealth services. Patients whose insurance status is unknown who pay out of pocket reacted more favorably (95.6%) to audio-visual telehealth services when seeing Behavioral Health Care Providers. Patients with private insurance coverage reacted more favorably (86.0%) to audio-visual telehealth services when seeing Somatic Care Providers.

Exhibit 3. Percent of providers who reported at least 50% of their patients reacted favorably to audio-only telehealth services

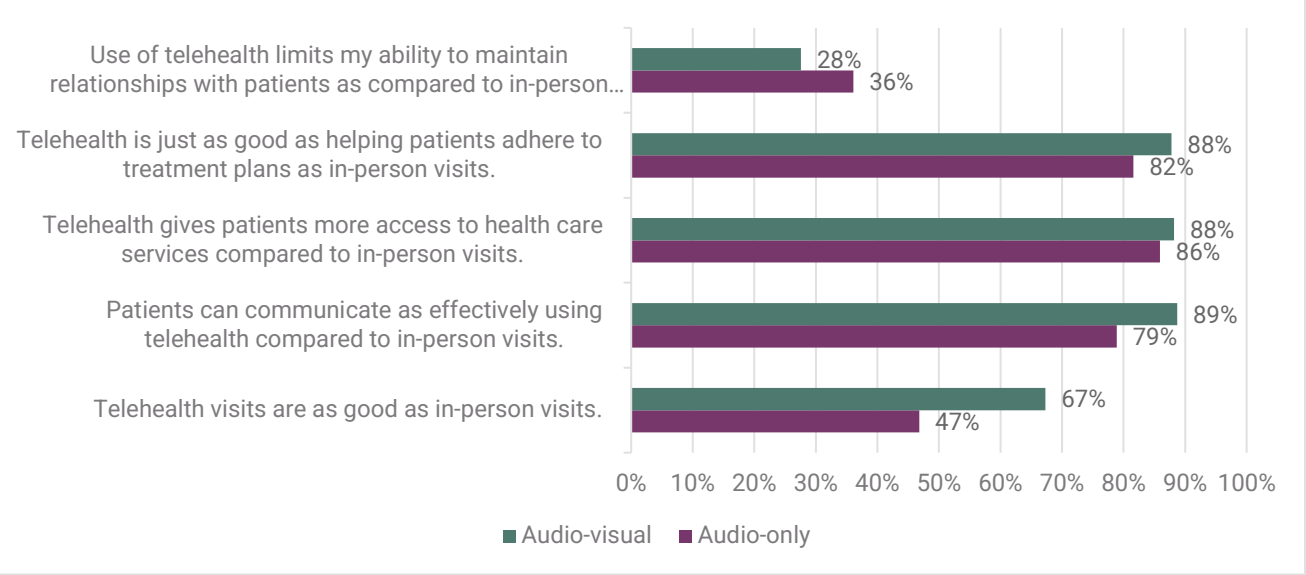


Note: For this question, only providers whose served client population was at least 10 percent of a given type were eligible to answer questions on favorability. This exhibit shows the different types of patient payment options that Somatic Care Providers and Behavioral Health Providers see and their preference for audio-only telehealth services. Patients whose insurance status is unknown who pay out of pocket reacted more favorably (93.9%) to audio-only telehealth services when seeing Behavioral Health Providers. Patients with private insurance coverage reacted more favorably (81.7%) to audio-only telehealth services when seeing Somatic Care Providers.

Perceived Effectiveness of Telehealth About nine out of ten behavioral health care providers and two-thirds of somatic care providers agreed or strongly agreed that audio-visual telehealth services are as good as in-person services (Exhibits 4 and 5). Somatic care providers were less likely than behavioral health care providers to indicate that audio-only telehealth services are as good as in-person services (47% vs. 60% respectively) and less likely to indicate that audio-visual telehealth services are as good as in-person services (67% vs. 89% respectively).

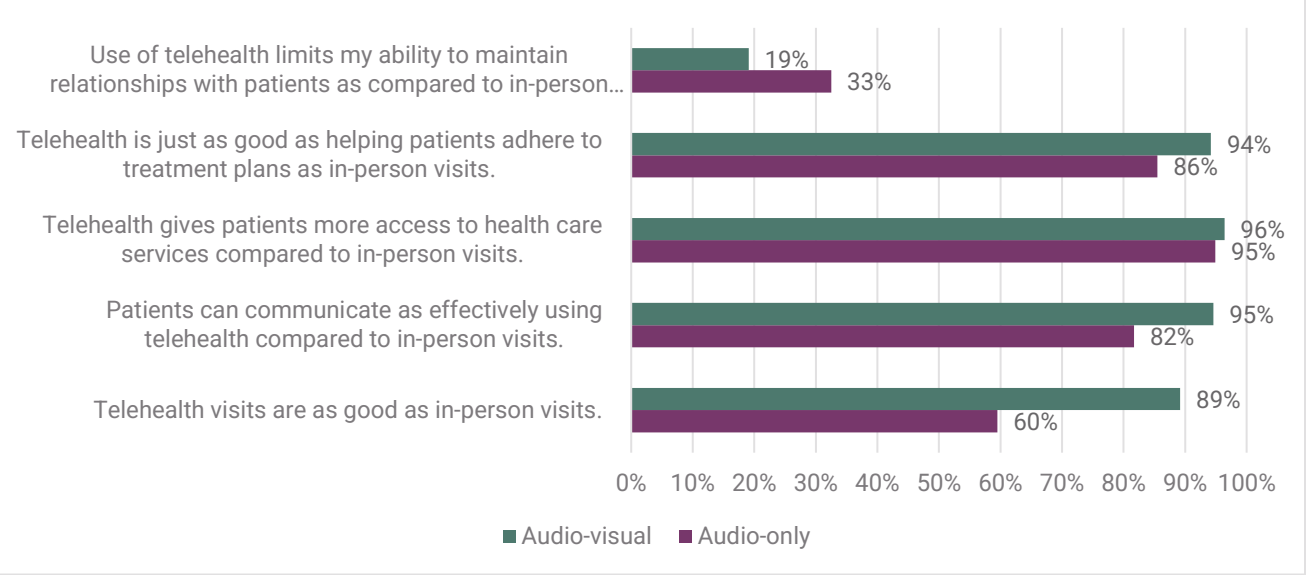
A small percentage of all provider respondents, between 19 and 27 percent, reported that audio-visual telehealth services limited their ability to maintain a relationship with patients compared to in-person services, with a slightly higher proportion among somatic care providers.

Exhibit 4. Somatic care providers' perceptions of the comparative effectiveness of telehealth relative to in-person care, for patients they have provided both telehealth and in-person services



Note: This exhibit provides insight into somatic care providers' perceptions on the effectiveness of telehealth care delivery and in-person care delivery. More specifically, the exhibit compares audio-visual and audio only telehealth services and examines the preferred method for somatic care providers to use between the two. The leading perception of the effectiveness of telehealth services was that telehealth gives patients more access to health care services compared to in-person services.

Exhibit 5. Behavioral health care providers' perceptions of the comparative effectiveness of telehealth relative to in-person care, for patients they have provided both telehealth and in-person services



Note: This exhibit provides insight into behavioral health care providers' perceptions of the effectiveness of telehealth care delivery relative to in-person care among patients who have received both in-person and telehealth services. The exhibit compares both audio-visual and audio-only services with the leading perception of the effectiveness of telehealth services being that telehealth gives patients more access to health care services compared to in-person services.

Barriers to Telehealth

Provider-level barriers. Somatic care providers were more likely than behavioral health care providers to identify low reimbursement as a deterrent to using telehealth. The majority of somatic care and behavioral health care providers reported that different payor rules for telehealth deter their use of audio-only telehealth (68.6% and 63.0% respectively) and audio-visual telehealth (63.9% and 58.8% respectively). Somatic care and behavioral health care clinicians were more likely to report low reimbursement as a deterrent to providing audio-only telehealth services compared to audio-visual services (Table 1). Somatic care providers were more likely than behavioral health care providers to identify low Medicaid and Medicare reimbursement as a deterrent to using telehealth, while behavioral health care providers were more likely than somatic care providers to report low commercial reimbursement as a deterrent.

Table 1 Percent of providers reporting low reimbursement as a deterrent to using telehealth

	Somatic Care		Behavioral Health Care	
	Audio-only	Audio-visual	Audio-only	Audio-visual
Low Medicaid reimbursement for telehealth deters my use of telehealth.	67%	57%	54%	44%
Low Medicare reimbursement for telehealth deters my use of telehealth.	65%	53%	52%	43%
Low commercial reimbursement for telehealth deters my use of telehealth.	66%	52%	70.%	57%

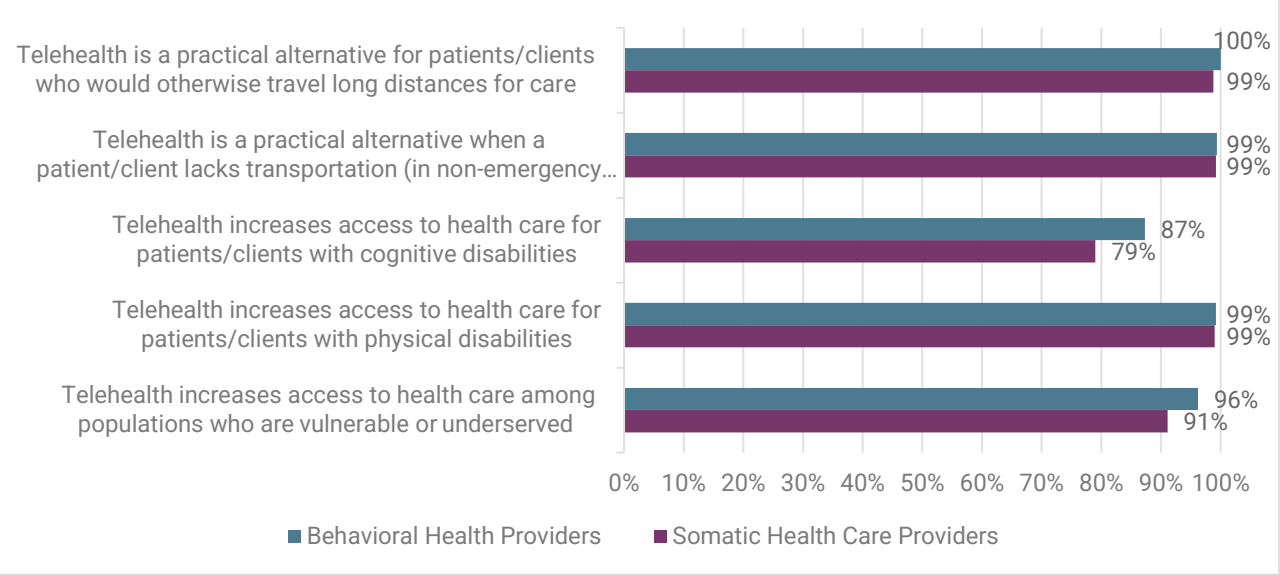
Patient-level barriers. Nearly three quarters (73%) of somatic care providers reported their patients' limited access to the internet or internet availability limits their use of audio-visual telehealth, compared to less than half (46%) of behavioral health care providers. Similarly, 71% of somatic care providers reported that patients' lack of digital literacy, or the ability to use and understand information from digital devices, reduced their ability to use telehealth with their patients. However, four in ten (39%) behavioral health care providers reported patients' lack of digital literacy as a barrier. Despite the prevalence of internet- or technology-related barriers, among providers who had discontinued audio-only telehealth services, a small percentage of providers (7% of somatic care providers and 2% of behavioral health care providers) cited lack of broadband or internet access among patients as a reason for discontinuing.

Access to Telehealth among Underserved Populations

The majority of providers agreed or strongly agreed that both audio-only and audio-visual telehealth services increase access to care for patients who might otherwise encounter access-related barriers (e.g., vulnerable or underserved populations, patients with disabilities, patients lacking transportation). For all statements that sought providers' perspectives on the use of telehealth to expand access to underserved populations, providers indicated a slight preference for audio-visual compared to audio-only services (Exhibits 6 and 7). Compared to somatic care providers, behavioral health care providers were slightly more likely to agree that both telehealth modalities increase access to care.

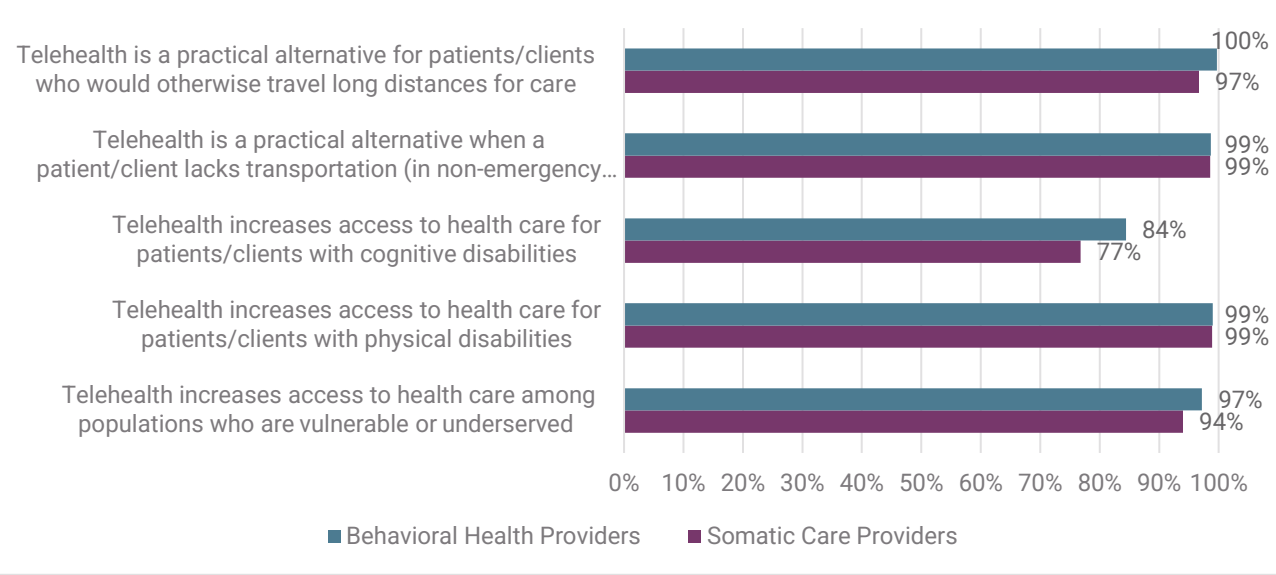
Although the majority of providers (87% of behavioral health care providers, 79% of somatic care providers) reported that telehealth increases access to care for patients with cognitive disabilities, this percentage was lower compared to other populations, including patients with physical disabilities (99% of behavioral health care providers, 99% of somatic care providers).

Exhibit 6. Provider perceptions on how audio-visual telehealth has affected care for different groups



Note: The exhibit shows provider perceptions on how audio-visual telehealth has affected care delivery for different groups. Both behavioral health care providers and somatic care providers had similar perceptions regarding how telehealth has affected care for different groups.

Exhibit 7. Provider perceptions on how audio-only telehealth has affected care for different groups



Note: The exhibit shows provider perceptions on how audio-only telehealth has affected care for different groups. Both behavioral health care providers and somatic care providers had similar perceptions regarding how audio-only telehealth has affected care for different groups.

Providers noted that patients with limited English proficiency are less likely to use telehealth. Approximately two-thirds of somatic care providers reported that clients with limited English language proficiency are less likely to use telehealth (70% for audio-only, 64% for audio-visual), compared to less than half of behavioral health care providers (42% for audio-only, 37% for audio-visual).

Discussion

Across study activities, consumers and providers reported that telehealth helped maintain access to care during the PHE. Consumers described convenience and elimination of barriers, such as transportation, as advantages of telehealth, particularly for populations residing in rural areas. Some noted that it offers patients more options in choosing their behavioral health care providers, protecting privacy, and reducing stigma. Somatic care providers were slightly less likely than behavioral health care providers to agree that both audio-only and audio-visual telehealth increase access to care, and less likely to indicate that both types of telehealth services are as good as in-person services. Consumers discussed how the appropriateness of telehealth varies depending on the purpose of the visit and whether in-person care is required.

There was a general preference across consumer interviewees and provider survey respondents for audio-visual telehealth over audio-only telehealth, with some exceptions. Consumers and providers noted improved patient-provider communication (e.g., better listening, ability to see facial expressions) via audio-visual telehealth as an advantage of this modality. However, audio-only telehealth was perceived as a beneficial modality for populations including people who lack internet or broadband access, and it was noted by some consumers to facilitate sensitive conversations during behavioral health care services.

There is significant policy interest in whether changes to telehealth coverage and reimbursement have reduced or exacerbated health disparities. Emerging evidence indicates that increased telehealth use may contribute to patient-level equity gaps in care. For example, access to broadband internet access is a barrier to using video-based telehealth services. Historically, communities of color and low-income and rural neighborhoods have been less likely to have access to high-quality broadband.[26] This connection shows that disadvantaged communities face barriers caused by internet access limitations that can prevent them from connecting with their provider through audio-visual telehealth.[26] Additionally, the expense of integrating audio-visual telehealth platforms into health care centers can pose barriers, especially for smaller or rural community health centers that often serve vulnerable and disadvantage communities.[26] As a result, many safety-net and community health centers had to rely on audio-only telehealth to maintain access to care.[26] Therefore, policymakers should consider how policies that limit audio-only reimbursement will impact communities that face barriers to accessing audio-visual telehealth services.[26]

These findings suggest that the preservation of choice—between telehealth and in-person care, and between audio-visual and audio-only telehealth—is a priority for providers and consumers and an important consideration for preserving access to care after the PHE ends.

[26] Karimi, Madjid, Lee, Euny, Couter, Sara, Gonzales, Aldren, Grigorescu, Violanda, Smith, Scott, DeLew, Nancy, Sommers, Benjamin. National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services. ASPE, February 2022. telehealth-hps-ib.pdf (hhs.gov)

Utilization of Care

This section describes the utilization of telehealth services during the PHE, by population (e.g., rural vs. urban), for somatic care and behavioral health care services. It assesses the patterns of telehealth use for Maryland residents and national patterns from the literature. The purpose of this section is to provide insight into consumer demand for telehealth services during the PHE, and the extent to which somatic and behavioral health care services were provided using telehealth technologies (and by telehealth modality, i.e., audio-only or audio-visual, when data is available). Findings are organized by study activity and include results from the literature review, claims analysis, and provider survey.

Utilization of Care: Literature Review Findings

Nationally, the utilization of telehealth services increased significantly during COVID-19. Prior to the PHE, telehealth services among Medicare FFS beneficiaries accounted for less than 1% of services across all specialties but increased in 2020 to 8% of primary care services and 3% of specialist services.[27] The largest increase was found in behavioral health care specialist services, one-third of which were via telehealth in 2020. Up to 70% of these services may have been audio-only services, but data limitations preclude clear identification of audio-only telehealth services.[28]

An analysis of outpatient visit data from over 50,000 providers in all 50 states, in settings including independent single-provider practices, multispecialty groups, federally qualified health centers (FQHCs), and large health systems, found that in December 2020, telehealth services (audio-visual and audio-only) as a percentage of baseline (March 1-7, 2020) outpatient services were 56% for behavioral health, 12% for adult primary care, and 8% for pediatrics.[29]

Disparities in telehealth utilization Between March 1, 2020 and February 28, 2021, 55% of Medicare beneficiaries (FFS and Medicare Advantage) in urban areas had a telemedicine service,[30] compared to 44% of Medicare beneficiaries in rural areas.[31] Utilization varied by race and ethnicity, with the highest uptake among Hispanic beneficiaries (64%), followed by American Indian/Alaska Native beneficiaries

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[27] Lok Wong Samson, W. T. (2021). *Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location.* ASPE https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf

[28] Ibid

[29] Ateev Mehrotra, M. E. (2021). The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge

[30] CMS. (2021). Medicare Telemedicine Data Snapshot Methodology. https://www.cms.gov/files/document/medicare-telemedicine-snapshot-methodology.pdf

[31] CMS. (2021). Medicare Telemedicine Data Snapshot Methodology. CMS https://www.cms.gov/files/document/medicare-telemedicine-snapshot.pdf

(58%), Black/African American and Asian/Pacific Islander beneficiaries (each 57%), and White beneficiaries (51%).[32]

Select Literature on Telehealth Utilization

The recent evidence on telehealth utilization demonstrates that the widespread growth in telehealth during the PHE across the Medicare, Medicaid, and commercial populations is shaping the future integration of telehealth with in-person care. Patient and provider experiences with audio-only and audio-visual telehealth for somatic and behavioral health care reflect the widespread acceptance of all modalities for receiving and delivering health care.

Where Virtual Care Was Already a Reality: Experiences of a Nationwide Telehealth Service Provider During the COVID-19 Pandemic[33].

This study described the utilization of telehealth services provided by Doctor on Demand; Inc. from February-June 2019 compared to February-June 2020. It also explored how the number of virtual services, reasons for services, and patients served changed over time. It examines four categories of services: respiratory illness, unscheduled behavioral health care, scheduled behavioral health care, and chronic illness. Key takeaways:

- In 2020, the total virtual visit volume increased considerably from March through April 7, 2020 (59% above the baseline) and then declined through the week of June 2 (15% above the baseline).
- Services for respiratory illnesses increased through the week of March 24 (30% above the baseline) and then steadily declined through the week of June 2 (65% below the baseline).
- Higher relative increases were observed for unscheduled behavioral health care and chronic illness services through April (109% and 131% above the baseline, respectively) before a decline through the week of June 2 (69% and 37% above the baseline, respectively).
- Increases in visit volume among rural residents were slightly higher than those among urban residents (peak at 64% vs. 58% above the baseline, respectively).

Select Literature on Telehealth and Disparities

The select articles below describe the impact of telehealth on health care disparities. While evidence of disparities persists and concerns remain about access to broadband internet, there is also evidence that diverse populations have been successfully accessing telehealth since the PHE was declared.

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[32] CMS. (2021). *Medicare Telemedicine Data Snapshot Methodology.* CMS https://www.cms.gov/files/document/medicare-telemedicine-snapshot.pdf

[33] Uscher-Pines L, Thompson J, Taylor P, Dean K, Yuan T, Tong I, Mehrotra A. Where Virtual Care Was Already a Reality: Experiences of a Nationwide Telehealth Service Provider During the COVID-19 Pandemic. J Med Internet Res. 2020 Dec 15;22(12):e22727. doi: https://doi.org/10.2196/22727. PMID: 33112761; PMCID: PMC7744145.

Patient Preferences for Patient Portal–Based Telepsychiatry in a Safety Net Hospital Setting During COVID-19: Cross-sectional Study[34].

The study examined patient preference for telehealth services either audio-visual or audio-only for their telepsychiatry services from June 15 and August 21, 2020, within a Safety Net Hospital. Additionally, documented demographic variables such as age, sex, race, ethnicity, insurance status, and homeless status. Key takeaways:

- The majority of patients preferred audio-visual services compared to audio-only services for their telepsychiatry services.
- Among patients who preferred audio-only services, some did not have internet access or access to a smart phone or computer.
- Patients who were older than 55 years of age were less likely to select an audio-visual visit compared to patients ages 18-54.

Telemedicine and healthcare disparities: a cohort study in a large healthcare system in New York City during COVID-19[35].

This study examined electronic health records (EHRs) in New York between March 19 and April 30, 2020 to examine the type of visit (telehealth or in-person), provider diagnosis code, and COVID-19 test results in addition to demographic data including zip-code, age, race/ethnicity, income, and education. Key takeaways:

- Telehealth is less likely to be utilized by African American patients compared to white patients.
- Telehealth utilization among African American patients increased during the pandemic but was still a lower level of utilization compared to white patients.
- Telehealth utilization ratios compared to in-person office or ED visits were lower among African American patients compared to other racial groups.

Disparities in telemedicine utilization among surgical patients during COVID-19[36].

This study examined a Department of Surgery outpatients seen between July 2019 and May 2020 to identify patient and surgery clinic characteristics associated with completion of a telehealth visit during COVID-19 compared to before COVID-19. Key takeaways:

- Telehealth visits were likely to be utilized among patients with an activated MyChart account.

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[34] Yue H, Mail V, DiSalvo M, Borba C, Piechniczek-Buczek J, Yule AM. Patient Preferences for Patient Portal-Based Telepsychiatry in a Safety Net Hospital Setting During COVID-19: Cross-sectional Study. JMIR Form Res. 2022 Jan 26;6(1):e33697. doi: https://doi.org/10.2196/33697.

[35] Chunara R, Zhao Y, Chen J, et al. Telemedicine and healthcare disparities: a cohort study in a large healthcare system in New York City during COVID-19. Journal of the American Medical Informatics Association: JAMIA. 2021 Jan;28(1):33-41. DOI: https://doi.org/10.1093/jamia/ocaa217

[36] Lattimore CM, Kane WJ, Fleming MA 2nd, Martin AN, Mehaffey JH, Smolkin ME, Ratcliffe SJ, Zaydfudim VM, Showalter SL, Hedrick TL. Disparities in telemedicine utilization among surgical patients during COVID-19. PLoS One. 2021 Oct 8;16(10):e0258452. doi: https://doi.org/10.1371/journal.pone.0258452

- Telehealth users were more likely to be female and pay with non-government or commercial insurance.
- Older patients and those living in rural communities were less likely to utilize telehealth visits during COVID-19.

Disparities in outpatient visits for mental health and/or substance use disorders during the COVID surge and partial reopening in Massachusetts[37].

This study examined changes in outpatient visits for mental health and substance use disorders in Massachusetts during a COVID-19 surge. Key takeaways:

- During the PHE surge there was an increase in visits for anxiety disorders and schizophrenia/bipolar disorders.
- Mental health and substance use disorder visits with primary care providers increased during the surge.
- The increase in volume was primarily among non-Hispanic whites and the decrease in utilization primarily among Hispanics and African Americans.
- Audio-only telehealth was primarily used for mental health and substance abuse disorder visits during the surge but declined as audio-visual visits became more popular.

Utilization of Care: Maryland Claims Analysis Findings

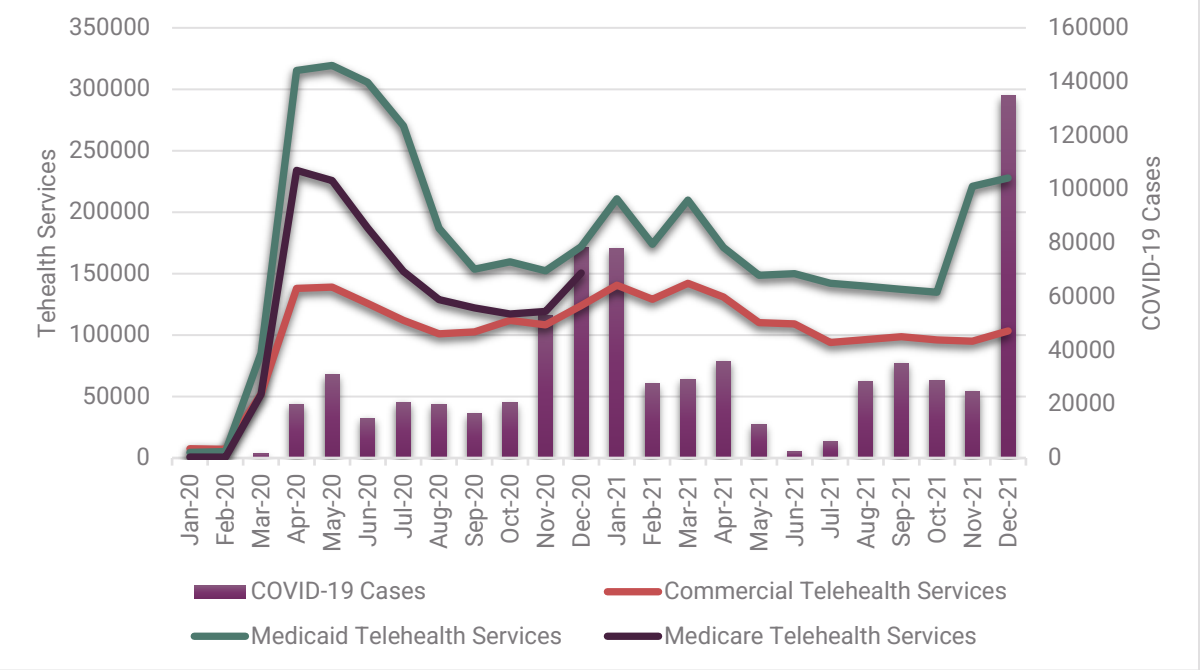
Trends in the monthly number of E&M telehealth services, January 2020 to December 2021

The peak in number of E&M telehealth services per month during the PHE in Maryland varied by payor (Exhibit 8). In Medicare[38] and Medicaid claims, the peak use occurred in the early months of the PHE, in April 2020 (234,031 telehealth services) and May 2020 (319,391 telehealth services) respectively. In commercial claims, the number of telehealth services peaked almost a year later in March 2021 with 142,112 telehealth services. However, this was a modest increase compared to 139,033 telehealth services in May 2020.

[37] Yang J, Landrum MB, Zhou L, Busch AB. Disparities in outpatient visits for mental health and/or substance use disorders during the COVID surge and partial reopening in Massachusetts. Gen Hosp Psychiatry. 2020 Nov-Dec; 67:100-106. doi: https://doi.org/10.1016/j.genhosppsych.2020.09.004

[38] This reflects Maryland Medicare claims data through December 2020; data for 2021 was unavailable at the time of analysis.

Exhibit 8. Number of E&M Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims

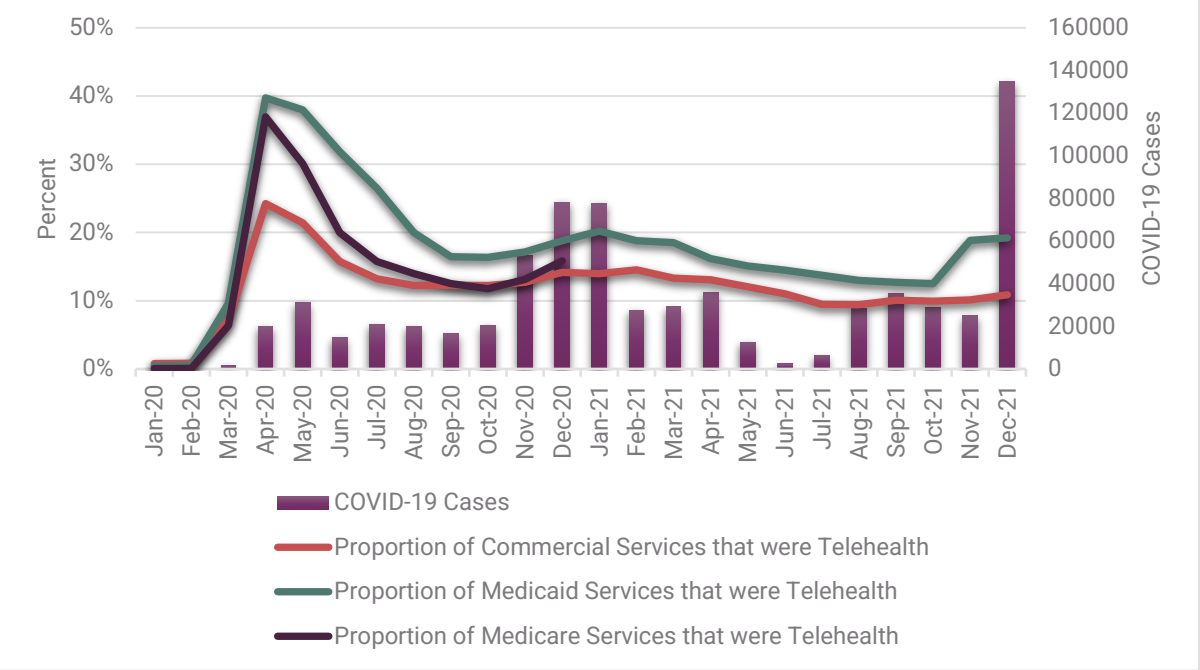


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the monthly number of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Trends in the monthly proportion of E&M telehealth services, January 2020 to December 2021

Prior to the PHE, telehealth accounted for less than 1% of E&M services across all payors. The proportion of E&M telehealth services per month in Maryland increased dramatically after the PHE began and peaked in April 2020 at 24% (commercial claims), 40% (Medicaid claims), and 37% (Medicare claims) (Exhibit 9).

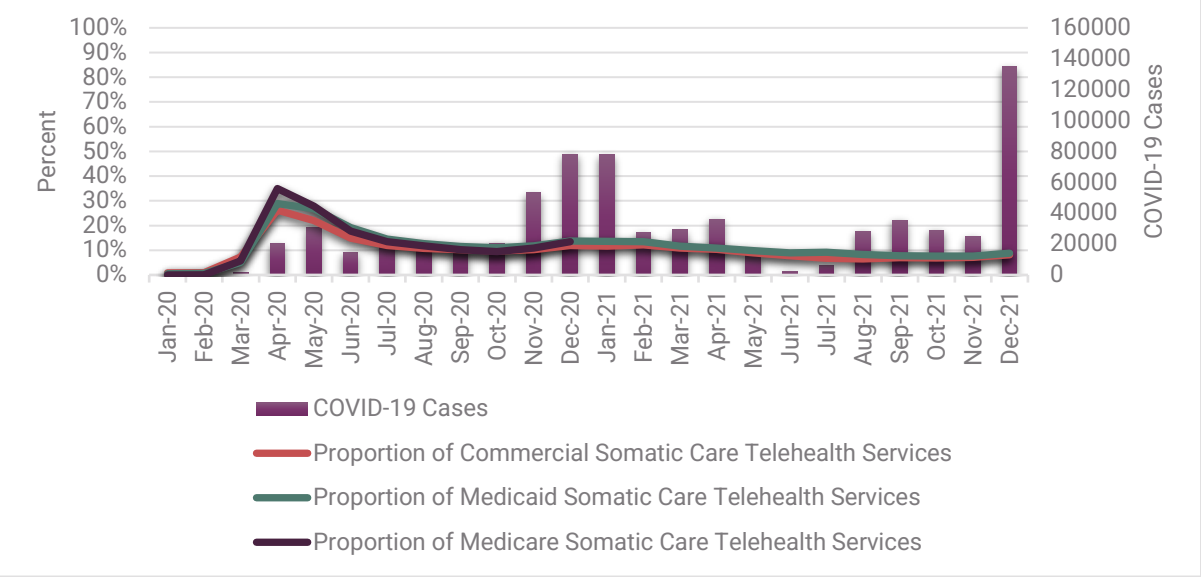
Exhibit 9. Proportion of E&M Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

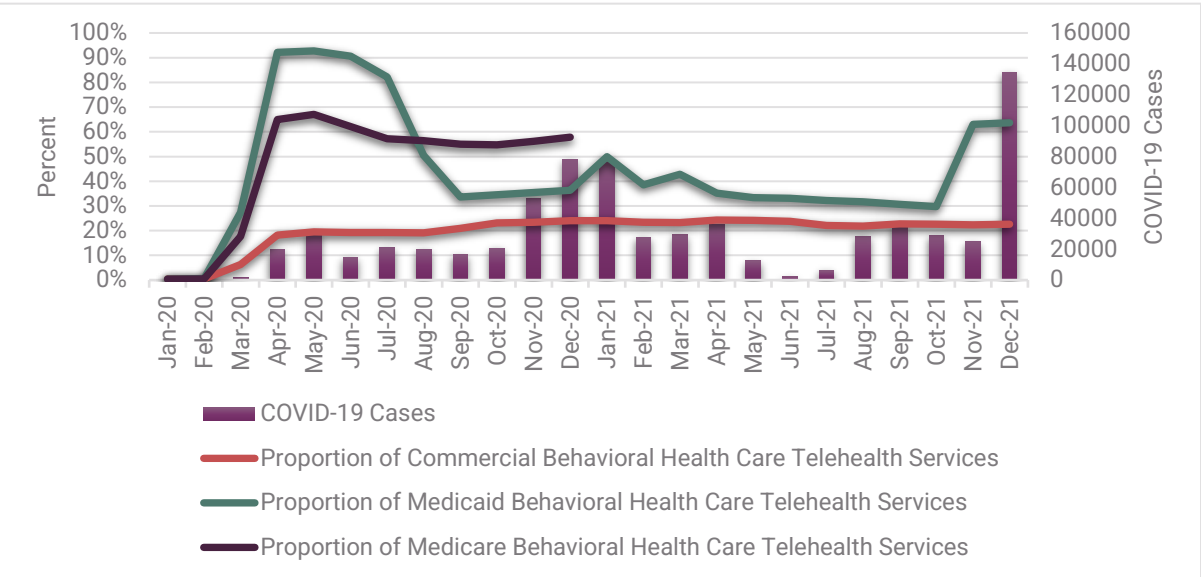
Exhibits 10 and 11 present the proportion of E&M somatic care telehealth services and E&M behavioral health care telehealth services per month across payors.

Exhibit 10. Proportion of Somatic Care Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims, Somatic E&M Services



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of somatic care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Somatic services were defined by BETOS subgroup codes EC, EE, EH, EI, EM, EN, EO, ER, EV, EX.

Exhibit 11. Proportion of Behavioral Health Care Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims, Behavioral E&M Services



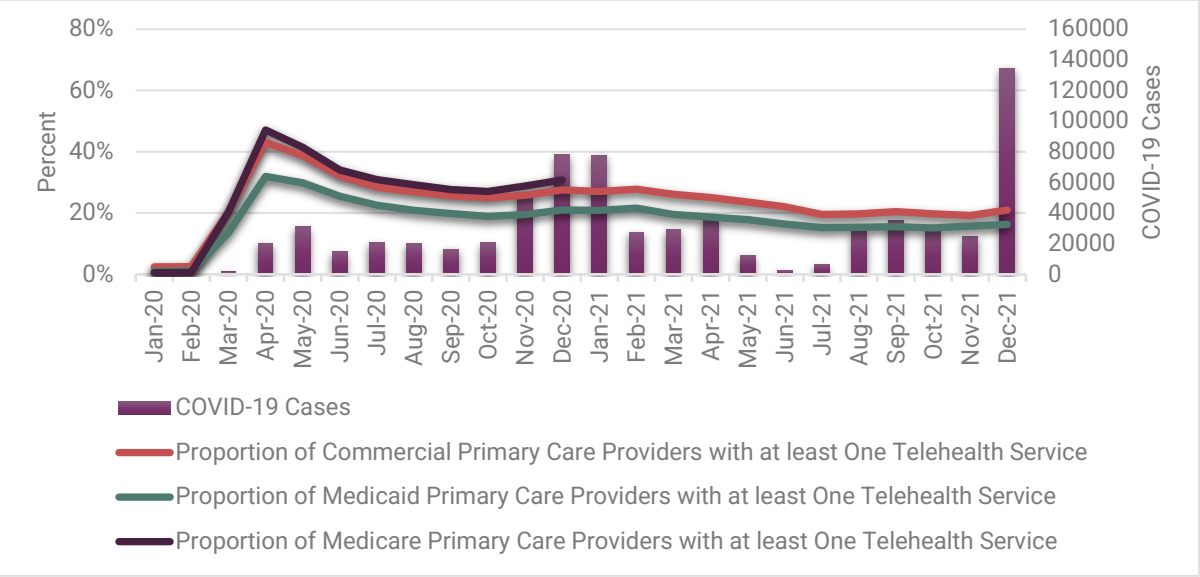
Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of behavioral health care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Behavioral services were defined by BETOS subgroup code EB.

Trends in monthly proportion of providers providing at least one E&M telehealth service, January 2020 to December 2021

Prior to the PHE, between 0% and 2% of providers across payors provided at least one E&M telehealth service. This percentage of providers increased significantly when the PHE began, peaking in April 2020, with 41% in commercial, 40% in Medicaid, and 49% in Medicare. The proportion of providers providing at least one E&M telehealth service decreased as the PHE progressed but remained higher than pre-PHE levels. In December 2020, 34% of providers in Medicare claims provided at least one E&M telehealth service. In December 2021, 27% of providers in commercial claims and 23% of providers in Medicaid claims provided at least one E&M telehealth service.

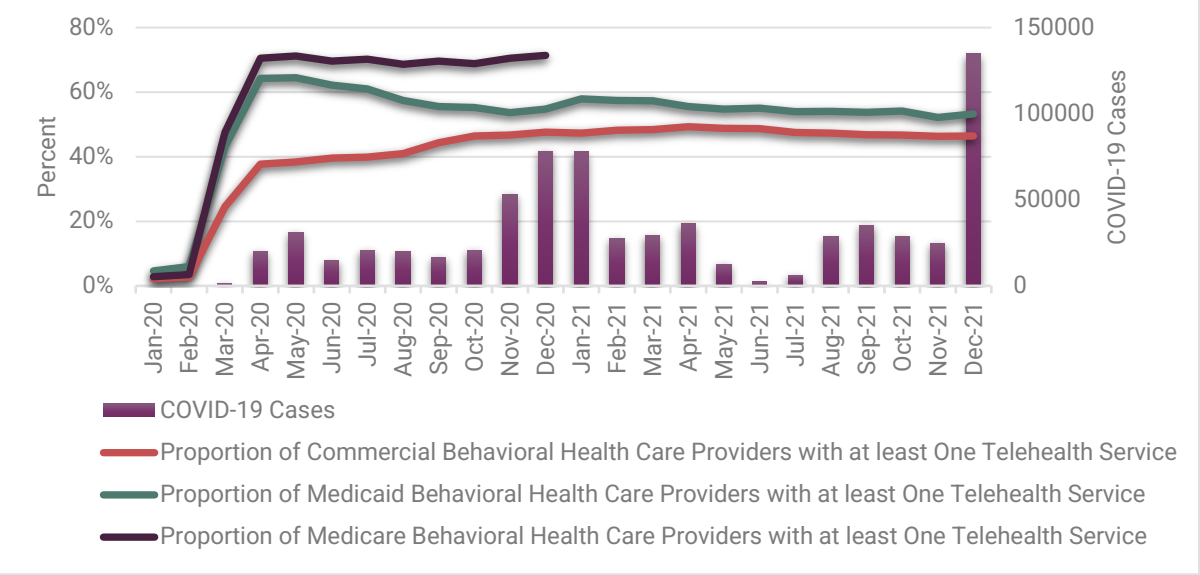
Exhibits 12 and 13 below present the proportion of primary care providers and behavioral health care providers with at least one E&M telehealth service per month. Among primary care providers, the proportion with at least one E&M telehealth service per month peaked in April 2020 and then declined, with modest increases in winter 2020-2021 months. Among behavioral health care providers, the proportion offering telehealth services generally increased or remained stable across the observed period, with some variation by payor. In Medicaid claims, the majority of behavioral health care providers offered at least one E&M telehealth service per month across the observed period.

Exhibit 12. Proportion of primary care providers with at least one E&M telehealth service per month in Maryland, 2020 to 2021, across commercial, Medicaid, and 2020 Medicare Claims, all primary care and specialty care providers with at least one E&M service



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of primary care providers with at least one telehealth service per month. Provider type was identified through specialty. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider types were identified using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and NUCC crosswalks.

Exhibit 13. Proportion of behavioral health care providers with at least one E&M telehealth service per month in Maryland, 2020 to 2021, across commercial, Medicaid, and 2020 Medicare Claims, all behavioral health care providers with at least one E&M telehealth service

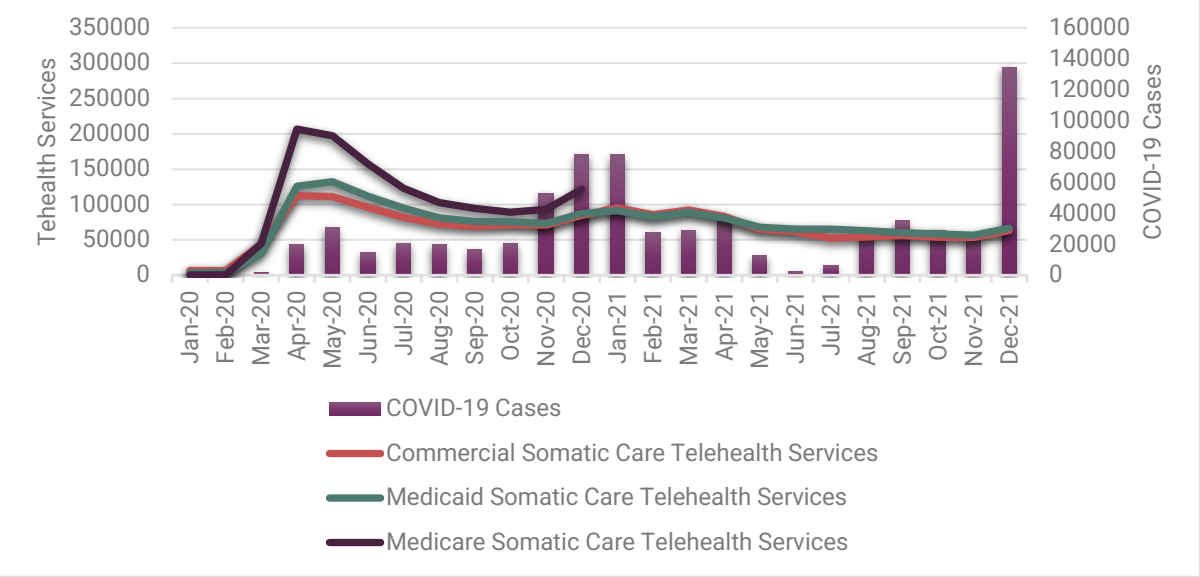


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the proportion of behavioral health care providers with at least one telehealth service per month. Provider type was identified through specialty. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider types were identified using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and NUCC crosswalks.

Trends in the number of E&M somatic and behavioral health care telehealth services, January 2020 to December 2021

Across payors, the number of somatic care telehealth services per month increased in March 2020 after the PHE began and peaked in April 2020 (Medicare, commercial) and May 2020 (Medicaid) (Exhibit 14).

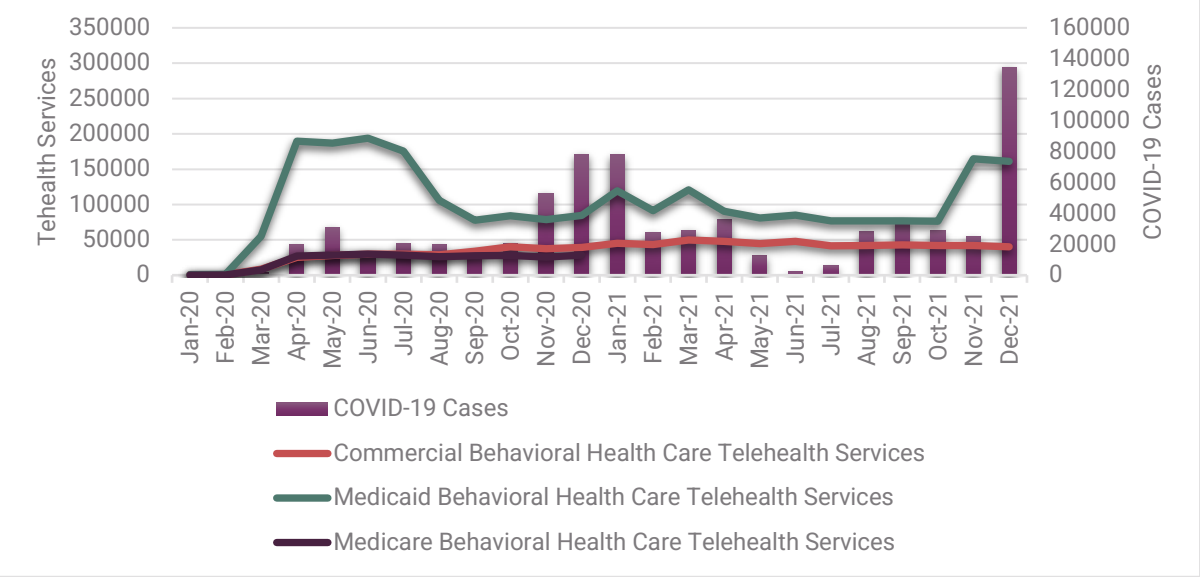
Exhibit 14. Number of E&M Physical Health Care Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the monthly number of somatic care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

The number of Medicaid E&M behavioral health care telehealth services increased in March 2020 and remained high between April and July 2020, peaking at 193,893 services in June 2020 and decreasing during the second half of 2020 (Exhibit 15). There were monthly fluctuations in 2021, with the number of services increasing in November and December 2021, preceding an increase in COVID-19 cases in December 2021.

Exhibit 15. Number of Behavioral Health Care Telehealth Services per Month in Maryland, 2020 to 2021, across Commercial, Medicaid, and 2020 Medicare Claims



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were used to identify the monthly number of behavioral health care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

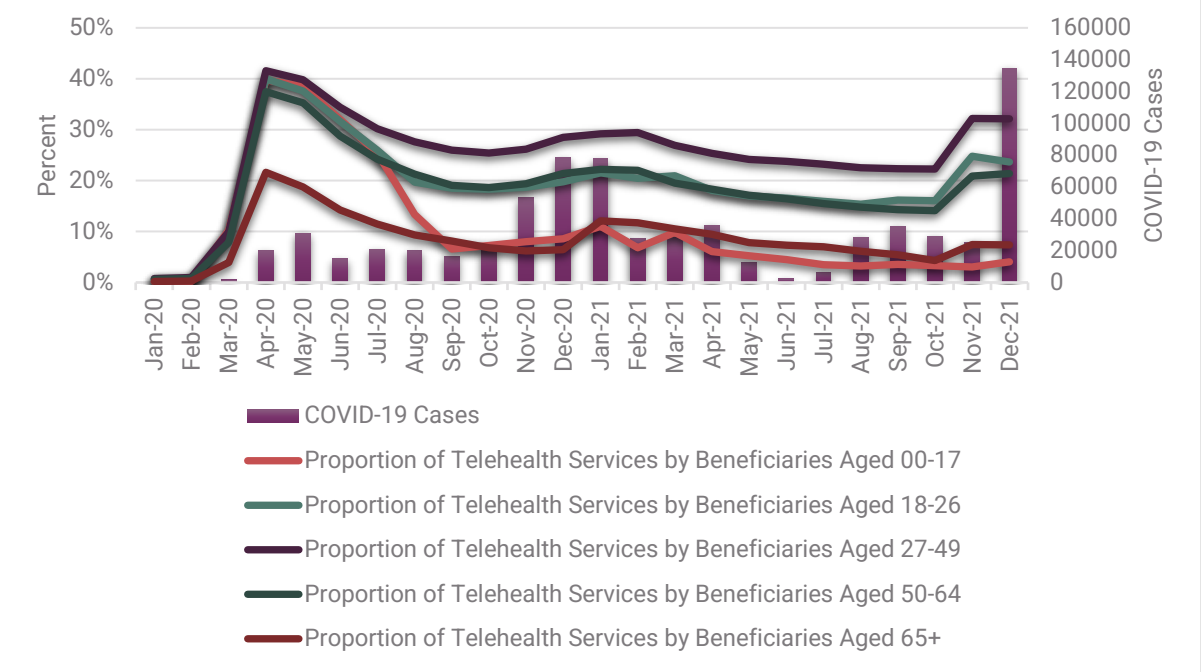
Disparities in E&M Telehealth Use, January 2020 to December 2021[39]

Gender. Across all payors and over the observed PHE period, there was a higher proportion of E&M telehealth services among female beneficiaries than male beneficiaries. This difference was significant for commercial claims.

Age. In commercial claims, the highest utilization of E&M telehealth services was among beneficiaries ages 27-49 and the lowest utilization was among beneficiaries ages 65+. These differences were significant across the observed period. Similarly, in Medicare claims, the proportion of E&M telehealth services was highest among the youngest beneficiary group (ages 27-49) and decreased for each subsequent age bracket, with the lowest utilization among beneficiaries ages 75+. In Medicaid claims, utilization of E&M telehealth services peaked across all age groups in April 2020, then decreased, with a sharp decrease among children (ages 0-17) from July to September 2020 (Exhibit 16).

[39] This includes Medicaid and commercial data for 2020-2021; data for 2021 Maryland Medicare claims was unavailable at the time of analysis.

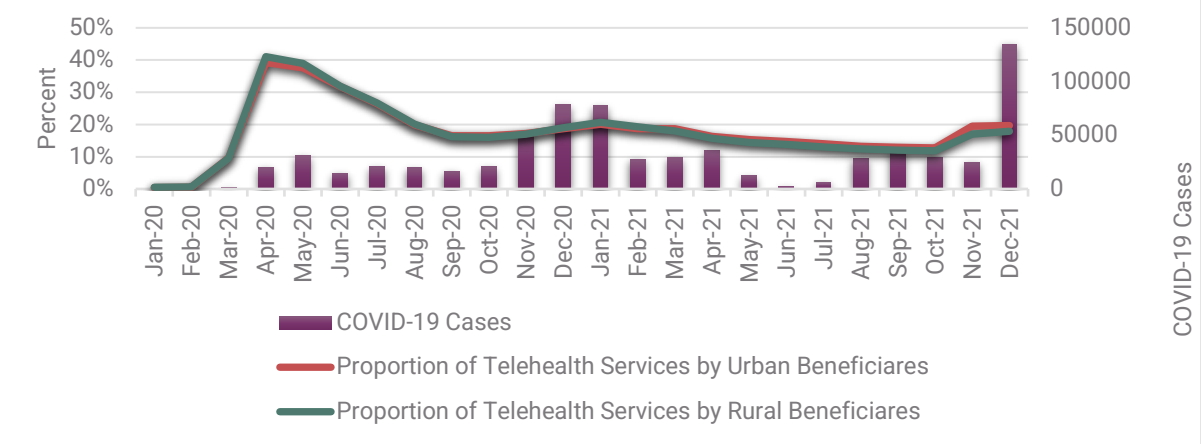
Exhibit 16. Proportion of E&M Telehealth Services by Age Group per Month in Maryland, 2020 to 2021, Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was used to identify the proportion of telehealth services by age per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Urban vs. Rural Status. In Medicare and commercial claims, across the observed period, there was a higher proportion of E&M telehealth services among urban beneficiaries than rural beneficiaries. This difference was significant for commercial claims. In Medicaid claims, the proportion of E&M telehealth services by urban or rural status was similar across the observed period (Exhibit 17). Across all payors and throughout the observed period, the percentage of urban beneficiaries with at least one E&M service and at least one E&M telehealth service was higher than the percentage of rural beneficiaries.

Exhibit 17. Proportion of Telehealth Services by Urban or Rural Status per Month in Maryland, 2020 to 2021, Medicaid Claims

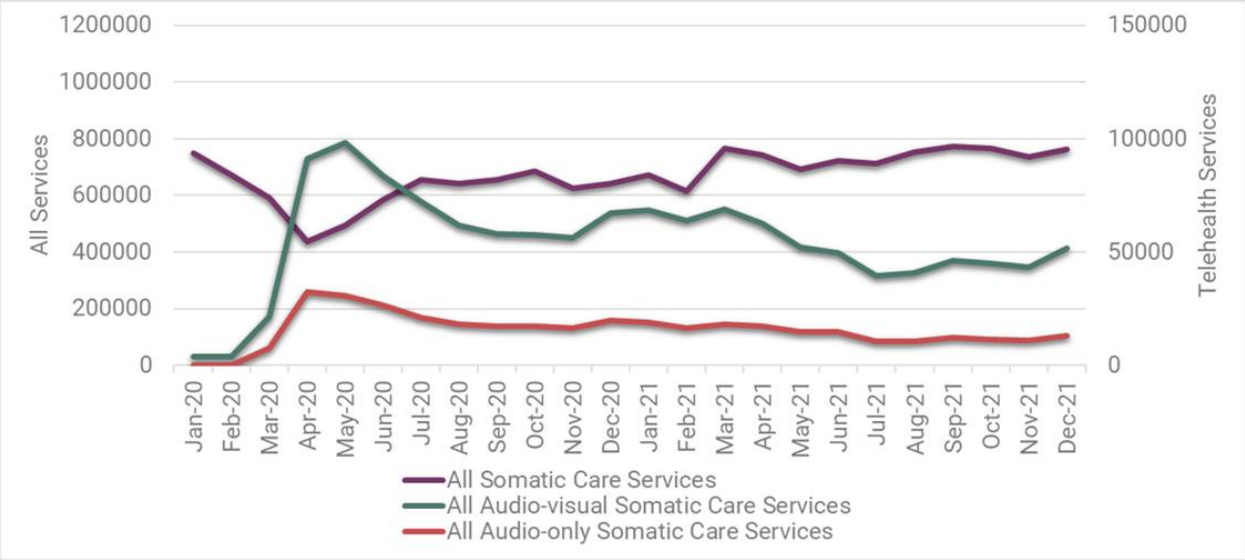


Notes: Maryland Medicaid claims data from 2020 to 2021 was used to identify the proportion of telehealth services by urban and rural status per month. Urban and rural status was determined at the county level and followed the rural/urban classifications established by the Rural Maryland Council. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was accessed to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Utilization of E&M audio-only and audio-visual telehealth services, January 2020 to December 2021

Somatic Health Care Services. In February to December 2020 commercial claims, E&M audio-only telehealth services were utilized more than E&M audio-visual telehealth services, and in January to December 2021, audio-visual services were utilized more than audio-only. However, the majority of commercial telehealth codes and a number of Medicare telehealth codes do not distinguish between audio-visual vs. audio-only modes, meaning that these conclusions are not definitive, and we were limited in our ability to conduct in-depth comparative analysis between E&M services delivered via audio-visual vs. those delivered via audio-only technologies. In Medicare, telehealth somatic E&M services were received primarily using audio-visual technology, but telehealth behavioral E&M services generally did not distinguish between audio-visual and audio-only technologies. Finally, in Medicaid claims, which do distinguish between audio-only and audio-visual services, audio-visual technology was utilized more than audio-only technology for E&M services across the observed PHE period (see Exhibit 18 for Medicaid claims).

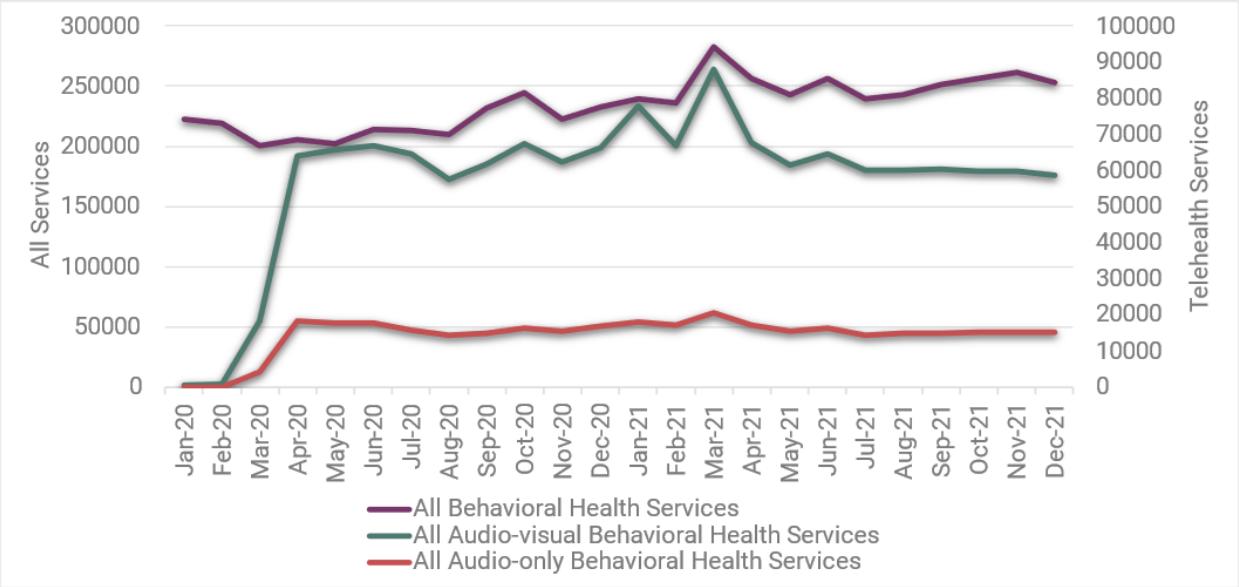
Exhibit 18. Differences in Utilization of E&M Telehealth Technologies of All Somatic Care Services per Month in Maryland, 2020 to 2021, Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was used to identify levels of service utilization for all services and for all telehealth services by technology. BETOS codes were utilized to determine somatic care service type. Unlike Commercial and Medicare telehealth codes, the Medicaid telehealth codes always distinguished between audio-visual and audio-only services – there were no claims in the "All Audio-visual or Audio-only Somatic Care Services" category.

Behavioral Health Care Services. In commercial and Medicaid claims, E&M audio-visual telehealth services were utilized more than E&M audio-only telehealth services across the observed PHE period (see Exhibit 19 for Medicaid claims). However, as noted above, the majority of E&M telehealth services in commercial claims were not distinguished by modality type (audio-visual vs. audio-only).

Exhibit 19. Differences in Utilization of E&M Telehealth Technologies of All Behavioral Health Care Services per Month in Maryland, 2020 to 2021, Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify levels of service utilization for all services and for all telehealth services by technology. Service type was identified through BETOS codes. Unlike Commercial and Medicare telehealth codes, the Medicaid telehealth codes always distinguished between audio-visual and audio-only services – there were no claims in the "All Audio-visual or Audio-only Behavioral Health Care Services" category.

Overall rates of utilization for office/outpatient E&M services and emergency room E&M services were lower during the PHE period relative to the pre-PHE period across all payers, with larger declines in emergency room services utilization, and particularly among Medicaid beneficiaries (Table 2). Rates of in-person office/outpatient E&M services utilization declined more than overall rates of office/outpatient E&M service utilization, which was somewhat attenuated by an increase in telehealth services. It is unclear whether the observed declines in utilization in office/outpatient and emergency room E&M services during the PHE period reflects an increase in unmet needs. Notably, rates of depression screening increased substantially during the PHE period compared to the pre-PHE period in the commercial population, driven almost entirely by in-person services.

Table 2 Rates of E&M Health Care Utilization Pre-PHE versus During PHE

	Pre-PHE			During PHE		
	Overall	**In-person**	**Telehealth**	**Overall**	**In-person**	**Telehealth**
Commercial						
Office/ outpatient	324	321	0	314	276	9
Emergency room	13	13	0	10	10	0
Depression screening	7	7	0	9	8	0
Medicaid						
Office/ outpatient	407	406	2	355	300	43
Emergency room	55	55	0	35	35	0
Depression screening	13	13	0	13	13	0.3
Medicare						
Office/ outpatient	742	741	0.3	648	500	147
Emergency room	51	51	0	36	36	0.1

Note: Utilization rates were calculated per 1000 beneficiary months, i.e., on average, for every month during the pre-PHE period, there were 324.16 office/outpatient services per every 1000 commercially covered beneficiaries.

Utilization of Care: Provider Survey Findings

When asked about the effectiveness of telehealth compared to in-person care, over 85% of somatic care providers and over 90% of behavioral health care providers indicated that telehealth increases the frequency of follow-up services, suggesting that telehealth increases utilization of health care services.

Approximately two-thirds of somatic care providers reported that patients with limited English language proficiency are less likely to use telehealth (70% for audio-only, 64% for audio-visual), compared to less than half of behavioral health care providers (42% for audio-only, 37% for audio-visual).

When asked about barriers to telehealth use, about one quarter of somatic care providers reported that staff at their organization need more training on telehealth, suggesting that increasing staff skills could increase the use of telehealth.

Discussion

Prior to the PHE, use of telehealth for E&M services was negligible among Maryland residents. However, after the PHE began, telehealth utilization for E&M services rapidly increased and the proportion of telehealth services to all services peaked across Medicaid, Medicare, and commercial payors in April 2020. The proportion of E&M telehealth services declined during subsequent months before stabilizing in fall 2020, at levels substantially higher than those observed pre-PHE. Notably, the proportion of E&M telehealth services stabilized at a substantially higher level in behavioral services than in somatic services. Patterns were generally similar in the proportion of providers who provided at least one E&M service via telehealth, with few providers using telehealth prior to the PHE, and a rapid uptake rate during the early months of the PHE. However, the proportion of behavioral health care providers utilizing telehealth technologies remained high for E&M services provided to Medicaid and Medicare populations, compared to providers using telehealth E&M services for the commercial population through the end of the analytical period. Utilization of E&M services via telehealth also varied by population subgroups: specifically, higher utilization was observed among younger individuals, those residing in urban areas, and female patients. Use of telehealth attenuated for some of the decline in overall rates of office/outpatient E&M services during the PHE across all three payers, with particularly pronounced effects in Medicare.

In Medicaid claims, there was higher utilization of audio-visual telehealth technology than audio-only telehealth technology for both somatic and behavioral E&M services. However, we are unable to draw definitive conclusions regarding the use of different telehealth technologies in Commercial and Medicare populations due to the lack of distinction between audio-visual and audio-only in the majority of Commercial telehealth codes, and Medicare behavioral health telehealth codes. Relatedly, the implementation of telehealth expansion was rushed under the PHE, and it is possible there was some degree of mis-categorization of telehealth and in-person services in provider billing practices, particularly in the early months. However, we are unable to determine whether if and to what extent mis-categorization may have occurred through an analysis of paid claims.

Generalizability of these findings beyond the analytical period used in the study is limited. The telehealth expansion was implemented during the PHE in response to the COVID-19 pandemic, which itself was an external shock to the provider and beneficiary behaviors. For example, there were substantial and differential declines in E&M services utilized across beneficiary demographic subgroups during the early months of the pandemic. Thus, it is reasonable to expect that telehealth-utilization behaviors observed during the pandemic differ from those that would have been observed had the telehealth expansion occurred in absence of a pandemic. Crucially, our analytical period ends in 2020 for Medicare and in 2021 for Medicaid and Commercial claims and includes a relatively short period of post-expansion follow-up time. It is unclear whether 2021 represents a post-intervention/pandemic period, and it is likely that various health care seeking behaviors, both in-person and via telehealth, were still fluctuating in response to COVID-related pressures. As such, should the telehealth expansion continue into future years in Maryland, it is unclear from this analysis how telehealth utilization will change as the risks of COVID continue to decline. Continued monitoring of the claims data, with

standardization of codes for billing, will help determine whether the telehealth use continues to remain stable or will drop to pre-PHE levels.

Finally, future research is also warranted to better understand whether similar trends in telehealth utilization are observed in non-E&M services, as well as the cost-effectiveness of telehealth utilization across different types of services and different population subgroups, and the efficiency of telehealth services (i.e. Whether telehealth services substitute for in-person services or instead lead to overuse of services) in Maryland.

Cost of Care

Assessing the cost of telehealth services is a perennial question for policymakers and various health care stakeholders as early evidence indicates telehealth and in-person care are complementary. Throughout the Maryland Telehealth Study, consumers and providers expressed a desire for care delivery choice that encompasses audio-only, audio-video, and in-person care. Before the PHE, Fair Health estimated that less than 1% of health care services in the U.S. were provided via telehealth, which provides limited comparative evidence to ascertain cost-effectiveness.[40] This section examines the cost of telehealth services by exploring emerging findings related to reimbursement of audio-only and audio-video telehealth technologies, coverage and payment parity, payment policies and recommended policy considerations. Findings in this section are organized by study activities including the literature review, consumer interviews, behavioral health care focus groups, and provider survey. This section does not include Maryland claims data due to data limitations.

Cost of Care: Literature Review Findings

According to the literature, audio-visual and audio-only modes of care are effective and convenient for clinicians and patients alike; however, there are nuances in telehealth delivery that future studies will need to examine. As pandemic restrictions ease, studies, and observations about the long-term fiscal effects of telehealth on the traditional health care market are slowly emerging. Most of these studies reflect an early evaluation of telehealth effectiveness and frameworks that may explain some conflicting policy considerations. Despite these policy variations relating to coverage and reimbursement, the literature suggests that telehealth (audio-only, specifically) has demonstrated a unique opportunity for behavioral health care clinicians and patients apart from somatic care. While somatic care and behavioral health care telehealth policy considerations may differ, emerging telehealth policy has the potential to shift current payment and delivery models, and regulatory requirements. The following excerpts include selected literature highlighting study findings related to cost:

[40]"States' Actions to Expand Telemedicine Access during COVID-19 and Future Policy Considerations." Commonwealth Fund, June 23, 2021. https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/statesactions-expand-telemedicine-access-covid-19

Calendar Year (CY) 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements Final Rule[41]

CMS published the Calendar Year 2022 Payment Policy codifying various aspects of telehealth services through December 31, 2023, as it continues to evaluate the inclusion of temporary telehealth services that were reimbursed during the PHE. CMS plans to collect additional telehealth services data to inform decisions about telehealth reimbursement post-PHE.[42]

Key Takeaways:

- Audio-only services for mental health will continue beyond the PHE.
- A patient's home is a permissible originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished during or after the end of the PHE
- Medicare telehealth services will reflect payment parity.

Fiscal Considerations for the Future of Telehealth: Health Policy Brief[43]

The telehealth policy considerations in this article urge policymakers to carefully consider implementing laws that may increase cost, utilization, and fraud, waste, and abuse. At a prominent level, Committee for a Responsible Federal Budget (CRFB) warns that payment parity could lead to providers being paid for shorter follow-up interactions and encourages low value, expensive care. For similar reasons, CRFB strongly urges that policymakers resist the call for payment parity between telehealth and in-person services ensuring that the Medicare physician fee schedule already accounts for overhead costs. Most notably, the CRFB report states that existing fraud and abuse challenges, such as upcoding and misrepresentation of services, present regulators with a new opportunity to strengthen quality and utilization measures that encompass telehealth. Since telehealth's expansion into the health care market during COVID, overall recoveries in health care fraud have doubled from $2.6 billion in FY 2019 to over $5 billion in FY 2021.

Key Takeaways:

[41] Calendar Year (CY) 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements Final Rule. Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS). November 2021. https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf

[42] Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule Fact Sheet. CMS. November 2021. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

[43] Committee for a Responsible Federal Budget. Fiscal Considerations for the Future of Telehealth: Health Policy Brief. CRFB; 2022. doi: https://www.crfb.org/sites/default/files/media/documents/Future_of_Telehealth.pdf

- Utilization – telehealth services should help reduce overutilization of care but could potentially increase patient utilization of health care services resulting in increased costs of care.
- Provider incentives – telehealth services could help providers reduce the cost of care, but payment incentives might lead to more costly care, especially if telehealth services continue to be reimbursed at parity with in-person care.
- Fraud and abuse – telehealth services are a monitoring concern.
- Mental health services – audio-only coverage for mental health services.

Task Force on Telehealth Policy Findings and Recommendations. National Committee for Quality Assurance (NCQA)[44]

The National Committee on Quality Assurance (NCQA) Task Force on Telehealth Policy has published a report of findings and recommendations collected over the pandemic period and informed by over 300 stakeholders. The findings and recommendations reflect the diverse views of these 300 stakeholders. Based on quality and cost data collected during the pandemic periods NCQA recommends a revaluation of telehealth policy and utilization from a fee-for-service (FFS) model to a value-based model. In this way, providers and consumers are allowed more flexibility to choose their modality of care.

Key Takeaways

- Telehealth services should be reimbursed based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services is essential to maximizing the benefit to patients and the system at large.
- When analyzing and discussing telehealth costs, policymakers should take a wider view and incorporate costs to patients and family caregivers, clinicians and other providers, and payors. These costs could—and should—include avoided transportation costs, time spent scheduling, preparing for, or waiting for a visit, missed work, child/elder care, missed appointments, and technology/infrastructure costs. Although a change in care modality may create new costs, policymakers should not examine these costs without considering "baked in" in-person costs.
- Accurately assessing the true value – including the cost and quality -- of telehealth utilization will require that policymakers focus on evidence of its effectiveness and its ability to meaningfully increase access to care, not previously-held assumptions. Data from the current public health emergency are a first look at the effect on Medicare costs of lifting telehealth restrictions and it does not, at this writing, reflect excessive or unnecessary utilization. However, long-term conclusions and policies based on costs and outcomes in Medicare can only be drawn from data derived during the relatively normal conditions that follow the pandemic. Increased behavioral health care utilization during the pandemic may provide a good example of meaningful increased access that has

[44] National Committee for Quality Assurance. Task Force on Telehealth Policy Findings and Recommendations. NCQA; 2020. https://www.ncqa.org/wp-content/uploads/2020/09/20200914_Taskforce_on_Telehealth_Policy_Final_Report.pdf

potential to improve outcomes and avoid future unnecessary and costly utilization. This will require further investigation.

Telemedicine: What Should the Post Pandemic Regulatory and Payment Landscape Look Like?[45]

The Commonwealth Fund addresses the telehealth overutilization and increased health care spending through policy considerations focused on value. In this brief, value is defined by quality, spending, and access. The following policy considerations are directed toward regulators and insurers:

- There should be no single telemedicine policy, just as there can be no single policy for insurance coverage of prescription drugs. In the same way different drugs yield different outcomes, telemedicine may provide health benefits for certain clinical uses.
- Telemedicine policy decisions should be formulated through the lens of value. Value is defined as the dollars per improvement in care outcomes and access to care, including reductions in travel time, disruption to lives, and need for childcare.
- The key to successful telemedicine policy is greater simplicity. The current regulatory and payment environment for telemedicine is extremely confusing. A telemedicine provider must consider federal policy, potentially 50 different state policies, and countless private plan policies. This confusion has been a major deterrent to use of telemedicine.

Cost of Care: Consumer Interviews Findings

Findings from the Maryland consumer interviews suggest somatic and behavioral health care audio-only and audio-visual services during the PHE provided cost savings related to convenience. Conversely consumers acknowledge that telehealth services particularly for care involving physical examinations may increase their cost as in-person follow up services were required. Interviewees are unclear about telehealth policies and coverage; this understanding gap is held by consumers and providers alike. The following paragraphs summaries the comments from Maryland consumers.

Consumers described cost savings associated with telehealth services. Consumer interviewees identified cost savings related to no transportation costs, the ability to participate in services from their homes, and providers waving copays during the COVID-19 PHE as facilitators to seeking telehealth care. Telehealth users also noted they maintained preventative care while avoiding urgent care and ED services and the associated copays.

[45] Mehtrotra A, Wang B, Snyder G. Telemedicine: What Should the Post Pandemic Regulatory and Payment Landscape Look Like? The CommonWealth Fund; 2020. doi: https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation

Consumers were unclear if and the extent to which their health insurance covered telehealth. While no users reported "surprise billing" associated with care received via telehealth, one user voiced frustration with receiving a bill for a behavioral health care appointment that they could not connect to due to technological challenges.
Consumers described telehealth services that required an in-person follow-up visit with potential negative consequences, such as delays in treatment and added out-of-pocket costs. A Maryland consumer described a telehealth visit that was not as comprehensive as in-person care and ultimately required an in-person visit.

Cost of Care: Behavioral Health Care Focus Groups Findings

Maryland behavioral health care provider and consumer organization participants echoed the findings from Maryland consumers and national literature as a cost-effective care delivery option that should be complementary to in-person care. Participants were keenly interested in future telehealth policies that include payment and coverage parity for behavioral health care. The following paragraphs summarize the focus group findings regarding cost.

Participants expressed an ardent desire for payment and coverage parity for telehealth that extends beyond the PHE. Provider participants explained that audio-only and audio-visual telehealth requires the same provider effort and fixed costs (e.g., office related expenses and administrative costs) as in-person care -- payments should cover these costs. Participants noted that payment and coverage parity for audio-only help offset the mental health workforce shortages and increases health equity for rural patients.

Participants advocated for expanded policies and opportunities to include telehealth as a care modality for behavioral health care services. Participants shared the benefits of telehealth as extending the reach of mental health paraprofessionals, increasing access for rural counties, reducing no-show rates, and the potential to reduce hospitalizations. Participants from both consumer and provider organizations described the benefits of having immediate access for patients during a mental health crisis that in the past would have triggered an emergency department or urgent care visit as both cost saving and lifesaving care.

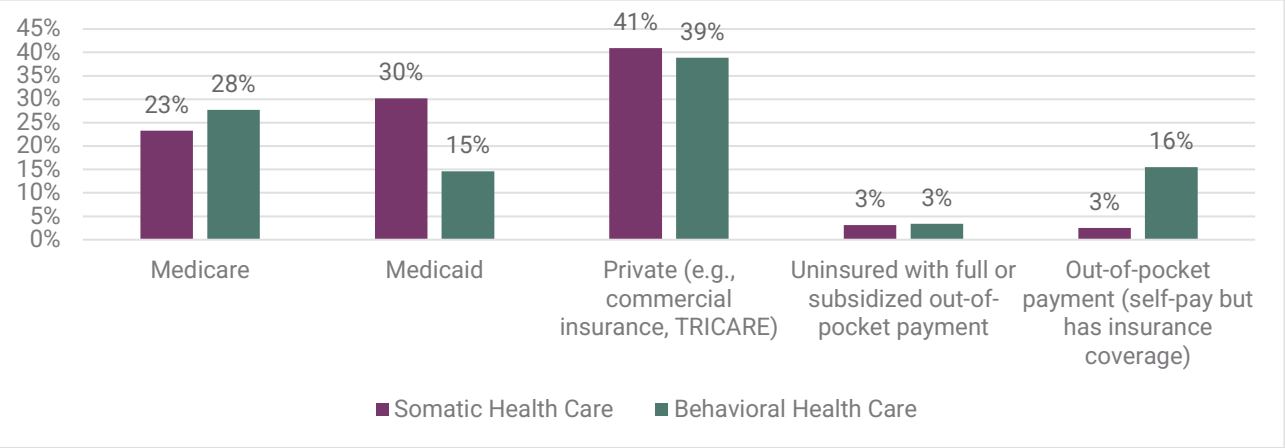
Participants identified Medicaid as the primary payor for telehealth behavioral health care services, followed by Medicare, charity care, commercial insurance, and self-pay. According to the focus group participants, future telehealth policy changes will primarily impact Medicaid patients and providers in Maryland. Yet, participants called for balanced coverage and reimbursement policies across payor types, as many behavioral health care providers have mixed patient payor profiles.

Cost of Care: Provider Survey Findings

The following findings from the Maryland provider survey examine aspects of cost for somatic and behavioral health care such as payor types, and audio-only and audio-visual reimbursement.

Providers were asked to estimate their patient payor mix for both telehealth and in-person care over the past year. Shown below in Exhibit 20 the greatest percentage of patients served by both somatic and behavioral health care providers were covered by private insurance (41% and 39%, respectively). Somatic care providers had a larger share of patients covered under either Medicare or Medicaid compared to behavioral health care providers. Behavioral health care providers had a larger percentage of patients who were paying for services out-of-pocket compared to somatic care providers.

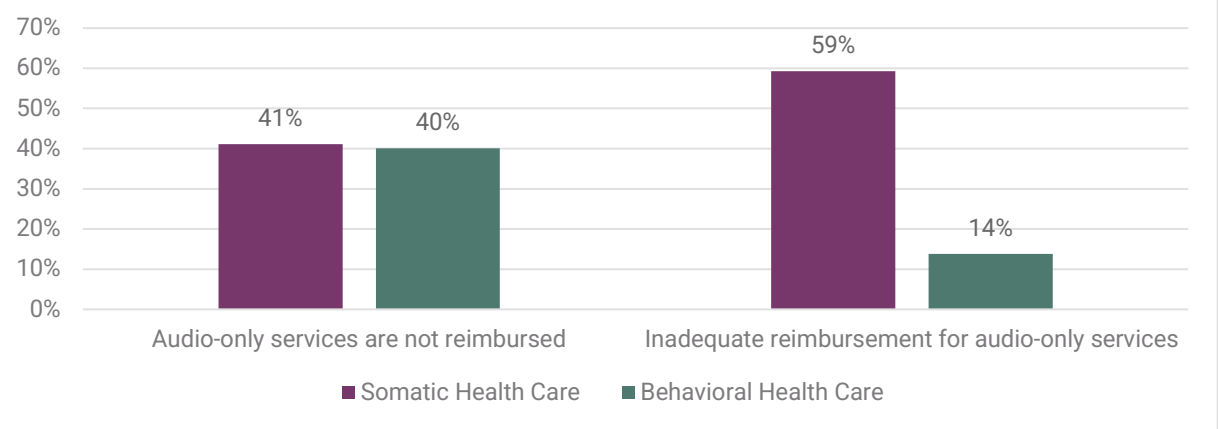
Exhibit 20. Provider Survey: Payor Mix Question



Note: This exhibit shows the provider responses to the payor mix question regarding the insurance type or payor option that their patients have. For both Somatic Health Care and Behavioral Health Care Providers, private insurance was the most common. The N for the responses were somatic care N=26,045 and behavioral health care N= 29,385.

Although over 85% of somatic care and 68% of behavioral health care provider respondents are using audio-only modalities, Exhibit 21 examines providers' responses when asked for reasons they would discontinue audio-only care. Somatic care providers most commonly reported inadequate reimbursement (59%) or lack of reimbursement (41%) as reasons for discontinuing use of audio-only services. Behavioral health care providers were also most likely to report lack of reimbursement (40.1%) as a reason for discontinuing audio-only services.

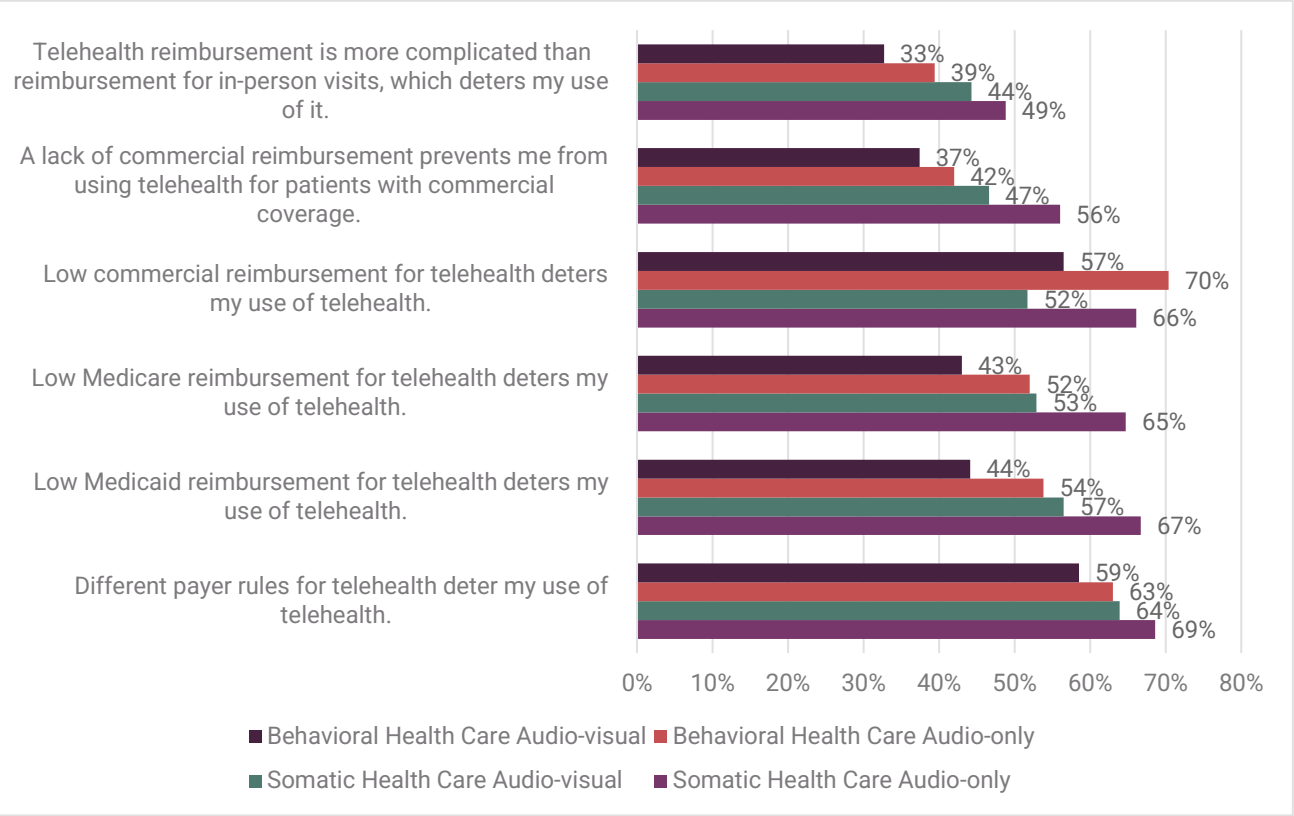
Exhibit 21. Provider Survey: Reason to Discontinue Audio-only



Note: This exhibit shows provider survey responses for reasons why audio-only services were discontinued. 41% of somatic care providers will discontinue audio-only if not reimbursed and 59% will discontinue for inadequate reimbursement. 40% of behavioral health care providers will discontinue when not reimbursed and 13.8% discontinue when inadequately reimbursed.

Respondents were asked about their perceptions on potential barriers to telehealth access, both audio-only and audio-visual services. Shown below in Exhibit 22 are the percentage of clinicians who agreed or strongly agreed with the statements as it relates to cost barriers. Overall, somatic (69% audio-only and 64% audio-visual), and behavioral health care (63% audio-only and 59% audio-visual) clinicians say different payor rules contribute to barriers. Somatic care providers (65-67%) reported that low reimbursement from payors as a deterrent to providing audio-only telehealth services compared to audio-visual services (52%-57%). 70% of behavioral health care providers reported that low reimbursement from commercial payors as a barrier to providing audio-only services. Across all payors, somatic care providers were more likely than providers to identify low reimbursement as a deterrent. Just over half of physical providers identified low reimbursement for audio-visual services as a deterrent whereas about two-thirds identified low reimbursement for audio-only services as a deterrent.

Exhibit 22. Provider Survey: Barriers to Telehealth Access



Note: This exhibit depicts the provider survey responses to barriers to telehealth access. For both types of providers, the audio-visual and audio-only care delivery options were included. Reimbursement for telehealth with varying insurance types seemed to be the most common reason for barriers to telehealth access for providers.

Discussion

Literature findings indicated that policymakers and health care stakeholders view telehealth optimistically yet are collecting more information to determine the appropriateness and longevity of temporary telehealth flexibilities in addition to the long-term cost effectiveness of telehealth. Maryland providers (somatic and behavioral health care) recommend implementing payment parity, reducing regulatory confusion, and allowing telehealth services as an option for care delivery. The literature review suggested that the regulatory variations between payors are a barrier that consumers and providers will continue to navigate for telehealth services.

The literature review findings and the behavioral health care focus groups suggested that audio-only services are uniquely clinically beneficial for mental health care. CMS has adopted the 2022 CY Medicare policy that extended audio-only mental health care beyond the PHE and allowed consumers to use their homes as the originating site. Additionally, states have broadened their regulatory requirements for Medicaid and private payor policies that will continue to provide robust evidence for studies related to cost effectiveness and quality.

Conclusion

The COVID-19 PHE supported the rapid expansion of telehealth services for somatic and behavioral health care in Maryland and nationwide through waivers that removed barriers to allow innovative telehealth service delivery. The telehealth expansion provided Maryland consumers and providers an opportunity to use audio-only and audio-visual technologies when in-person care was shuttered and continues to be used as mode of care delivery. Based on this experience, consumers and providers support making access to telehealth services a permanent mode of care delivery in Maryland, which is reflected in MHCC's Permanency of Telehealth Coverage and Technology recommendations (MHCC Recommendations 1-6).

Maryland consumers and providers indicated they preferred the option of a telehealth visit for somatic and behavioral health care, including the choice of using audio-only or audio-visual technologies, recognizing that audio-visual is preferred. In addition, Maryland consumers described advantages of telehealth including convenience, agency in choosing a provider, reducing transportation and childcare costs, and protecting privacy, particularly for behavioral health care. To maintain access to telehealth services in Maryland that address privacy and security concerns, MHCC identified three recommendations: (1) – allow use of telehealth by any licensed, certified, or otherwise authorized health provider, (2) – allow audio-visual technology, and under certain circumstances audio-only technology, and (6) – utilize communications technology that complies with privacy and security requirements.

Consumers and providers also noted that allowing consumers to receive telehealth services at home from health care providers at a distance site increases access to care, particularly for rural residents and those with mobility challenges. MHCC's Recommendations 3 - 5 -- (3) define and allow remote patient monitoring, (4) allow hospice care services to use telehealth, (5) allow telehealth in hospital inpatient and nursing home settings – support meeting consumers' health needs where they are physically located and reduce the need for patients to travel to a provider to access care, particularly when patients are frail or receiving end-of-life care.

Adequate coverage and reimbursement were key issues for consumers, providers, and behavioral health focus group participants to maintain access to telehealth services in Maryland. Providers recommended payment parity for telehealth services because the fixed costs of providing telehealth and in-person care are comparable. MHCC's Telehealth Payment Level Recommendation – (7) continue payment levels for telehealth services relative to in-person care for 24 months -- addresses the coverage and reimbursement concerns raised in the study and includes two additional years to observe how telehealth is used in Maryland. This extended time will allow MHCC to conduct a robust study of telehealth experiences in Maryland to examine payment parity for audio-only and audio-visual technologies, cost-effectiveness, quality, and determine if telehealth advances health equity. In addition, we learned from conducting this study how improvements can be made to enhance the quality

of claims data, such as populating race and ethnicity variables and using codes that distinguish audio-only from audio-visual telehealth visits, that will enhance future study findings.

Across the country there is great interest among policy makers, payers, providers, and consumers in exploring the post-pandemic future of telehealth. Many state and national studies are underway to better understand the efficacy of telehealth services, which will contribute to an evidence-base to inform policy. During the next two years, Maryland is well-positioned to learn from its own telehealth experience as well as from the myriad of telehealth research in progress. Collectively, these experiences and study findings will help inform the 2025 Maryland General Assembly as it considers the path forward for Maryland's telehealth policies.

Appendices

Appendix A: MHCC Research Questions

Exhibit 23. MHCC Research Questions

Topic	Research Question
Access to care	What policy or statutory reforms, if any, are needed to continue or further expand the use of telehealth?
	As greater shares of the population are vaccinated against COVID-19 and infection rates decline, how much will primary care providers return to a pre-PHE mindset that generally favors in-person care?
	How have changes to telehealth coverage and reimbursement reduced or exacerbated health disparities?
	What is the potential impact on disparities if telehealth expansion laws abrogate on June 30, 2023?
Utilization	What insights can be derived from utilization and challenges and opportunities for audio-only and audio-visual technologies in behavioral health care as compared to somatic care?
	What types of somatic and behavioral health services can reasonably be provided using audio-only technologies long-term?
	Is telehealth evolving faster than the evidence to support its cost-effective use?
	How has consumer demand for audio-only and audio-visual visits evolved since the onset of the PHE and since the spring of 2021 with the increasing availability of COVID-19 vaccinations and declining infection rates? What are key reasons that can be attributed to the current state of telehealth utilization?
	Are privacy and security risks related to provider-to-provider, provider-to-consumer, and remote patient monitoring communications deterring use of telehealth among providers and/or consumers?
Cost	Should audio-only visits be reimbursed at a lesser rate than audiovisual visits in somatic and behavioral health care? Are there cost differences between somatic and behavioral health care that warrant paying equivalent rates to in-person visits for either of the two categories of care?
	Should reimbursement for audio-only become a permanent feature of the health care system or phased out over time? If audio-only is to continue, what are the main differences in telehealth and in-person care that justify continuation of audio-only services?
	What features of alternative care delivery models further the cost-effective use of telehealth and what features deter use of telehealth?
	To what extent are audio-only and audio-visual visits delivered during a specific episode of care triggering subsequent follow-up in person care within a 30-day period?

Appendix B: Institutional Review Board Certification - Exemptions

Exhibit 24. Institutional Review Board Certification – Exemptions

NORC at the University of Chicago

Institutional Review Board Certification
Amendment Review - Exemption

PRINCIPAL INVESTIGATOR:	Alana Knudson
DEPARTMENT:	Health Care
PROTOCOL NUMBER:	21-11-549
PROTOCOL TITLE:	MHCC Telehealth Study

null

Review Date: May 03, 2022

This certifies that the changes to the protocol described above have been reviewed. The IRB finds that the changes do not affect the original exempt determination and remain consistent with exemption category previously designated.

Any additional amendments or other changes to this protocol must be submitted for review by the IRB, and all adverse events must be reported to the IRB.
Please notify the IRB when your study has closed.

Micah Sjoblom

Page: 1

Exhibit 25. Institutional Review Board Certification – Provider Survey & Consumer Interviews

NORC at the University of Chicago

Institutional Review Board Certification

Determination of Not Human Subjects Research

Principal Investigator/Project Director: Alana Knudson
Department: Public Health
IRB Protocol Number: 21-12-575
Protocol Title: MHCC Telehealth Study - Survey and Interviews

Determination Date: December 20, 2021

This certifies that the protocol described above was submitted for review and it is determined that the activities do not meet the definition of human subjects research by the NORC Institutional Review Board (IRB00000967), under its Federal Assurance #FWA00000142, which is valid through July 19, 2023.

Karen Grigorian

Appendix C: Provider Survey Questions

Exhibit 26. Provider Survey Questions

MARYLAND Health Care Commission

NORC at the University of Chicago
4350 East-West Highway, 8th Floor
Bethesda, MD 20814

Telehealth Study Questions

Introduction/Consent
Thank you for participating in our telehealth survey of Maryland health care providers! **We value your input.** This survey is part of a statutory requirement *Preserve Telehealth Access Act of 2021* passed by the Maryland General Assembly. The law requires the Maryland Health Care Commission (MHCC) to conduct a telehealth study that will provide information to help develop recommendations on telehealth coverage and reimbursement for the 2023 legislative session. NORC at the University of Chicago is conducting this survey under contract with MHCC to evaluate the effects of the expansion in telehealth coverage.

Your responses will be kept confidential. At the end of the study, de-identified data will be provided to MHCC.

Instructions
Please use the "Continue" and "Previous" survey buttons **on the bottom of the screen** to navigate through the questions in the survey. You must use the "Continue" button on the screen after you have responded to a question for your answer to be saved. **Please do not use your browser buttons**.

To exit the survey at any time, simply close your internet browser window. Any data you have entered before closing will be saved. Reopening the survey later will allow you to return to the same location and finish completing the survey.

You may work at more than one practice location. Please provide responses about your experiences at the site **where you use telehealth. If you use telehealth at more than one location, please consider the setting where you spend most of your time**.

You may use telehealth to communicate to caregivers of patients. You can include experiences with telehealth that involve caregivers.

Lastly, we provided definitions on certain terms throughout the survey. When available, you can hover over the light bulb image next to the term for more information.

Again, we greatly appreciate your time and participation. Let's get started!

[Note: Behavioral health care providers will see the word "client" in place of the word "patient" in survey questions. Otherwise, questions are the same for all provider types. The use of the term "client" for behavioral health care providers was suggested by pilot respondents and reflects differences in professional orientation to service delivery.]

1. **Which telehealth modalities for patient care, if any, do you currently use?**
   Note: Images and diagnostic tests stored and then electronically sent to another provider and ongoing monitoring of patients using medical devices outside of conventional care settings, such as in the home (e.g., remote patient monitoring), are not considered telehealth.

   Audio-only: interactive telecommunications with patients using telephone calls.

   [ ] Currently use
   [ ] Discontinued
   [ ] I have not adopted this mode of telehealth

   Audio-visual: interactive telecommunications with patients using both audio and visual technology, including audio-visual technology without the video enabled.

   [ ] Currently use
   [ ] Discontinued
   [ ] I have not adopted this mode of telehealth

2. [ASK IF 1b = currently use OR discontinued] Which **audio-visual technologies do you use with your patients? Please provide the names of all the audio-visual technologies that you use (e.g., Doxy.me, Zoom, etc.).**
   [ ] _____

   2a. [ASK IF 1 = discontinued for audio-only OR audio-visual] Why **did you stop using** [audio-only / audio-visual] telehealth? **Select all that apply.**
   [ ] The security of personal health data transmitted electronically is a concern.
   [ ] The inability to confirm patient identity deters my use of telehealth.
   [ ] It is not possible to achieve care goals via telehealth.
   [ ] I or providers at my practice do not feel sufficiently trained to deliver care via telehealth.
   [ ] It is difficult to establish a relationship or rapport with patients.
   [ ] It is difficult to maintain a relationship or rapport with patients.
   [ ] It is difficult to confirm privacy for HIPAA purposes.
   [ ] I do not feel able to perform a comprehensive examination.
   [ ] My patients prefer to receive in-person care.
   [ ] Audio-only services are not reimbursed.
   [ ] Inadequate reimbursement for audio-only services.
   [ ] Audio-visual services are not reimbursed.
   [ ] Inadequate reimbursement for audio-visual services.
   [ ] My patients are not comfortable with or lack knowledge about how to use the software required to use telehealth.
   [ ] My patients lack access to broadband/internet.
   [ ] The practice where I work elected to discontinue the use of telehealth.
   [ ] State guidelines or regulations regarding the use of different technologies are not clear.
   [ ] Variable regulations and guidelines increase the potential for liability and legal issues.
   [ ] Other (please explain): _____

2b. [ASK IF 1a or 1b = Practice has not adopted this mode of telehealth] Why **has your practice not adopted the use of** [audio-only / audio-visual] **telehealth? Select all that apply.**

[ ] The security of personal health data transmitted electronically is a concern.
[ ] The inability to confirm patient identity deters my use of telehealth.
[ ] It is not possible to effectively deliver care via telehealth.
[ ] It is difficult to establish a relationship with patients.
[ ] I or providers at my practice do not feel sufficiently trained to deliver care via telehealth.
[ ] I do not feel able to perform a comprehensive examination.
[ ] My patients prefer to receive in-person care.
[ ] It is difficult to maintain a relationship or rapport with patients.
[ ] My patients are not comfortable with or lack knowledge about how to use the software required to use telehealth.
[ ] My patients lack access to broadband/internet.
[ ] It is difficult to confirm privacy for HIPAA purposes.
[ ] My practice does not have the technology required to deliver telehealth.
[ ] State guidelines or regulations regarding the use of different technologies are not clear.
[ ] Variable regulations and guidelines create increased potential for liability and legal issues.
[ ] Other (please explain): _____

3. **Which practice type best describes where you work?** If you use telehealth at more than one location, please consider the setting where you spend most of your time.
   [ ] Employee or owner of a physician-owned private practice
   [ ] Individual private practice
   [ ] Physician-owned outpatient hospital
   [ ] School based setting
   [ ] Community outpatient facility
   [ ] Community mental health center
   [ ] Federally Qualified Health Center
   [ ] Hospital-owned inpatient
   [ ] Hospital-owned outpatient
   [ ] Other (please explain): _____

4. **For which payer types do you participate in Value-Based Payment programs? Select all that apply.** [Value-Based Payment is defined as paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care.]

   [ ] Medicare
   [ ] Medicaid
   [ ] Commercial insurance
   [ ] I don't know.
   [ ] I do not participate in any Value-Based Payment programs.

[IF 1 = "Practice has not adopted this mode of telehealth" for BOTH audio-only and audio-visual – STOP]

Those are all the questions we have for you. Thank you for your participation!

5. Next, thinking about all the patients for whom you provide services (telehealth and in-person) over the past year, please tell us approximately what percent of patients are covered by each type of payer shown below. Your best estimate is okay.

Type of Payer	Percent of all patients
Medicaid	
Medicare	
Private (e.g., commercial insurance, TRICARE)	
Uninsured with full or subsidized out-of-pocket payment	
Out-of-pocket payment (self-pay but has insurance coverage)	

6. Since July 2021, about what percentage of telehealth services have you provided to patients with whom you had an established relationship? By established relationship, we mean seen in-person at least once prior to the telehealth visit. Your best estimate is okay.

[ ] Less than 10%
[ ] 10% to < 25%
[ ] 26% to <50%
[ ] 51% to 75%
[ ] More than 75%

Now we would like to know about your perceptions of the **effectiveness** of treatment delivered via telehealth. Effectiveness of treatment refers to the ability to achieve care goals. We are **not** asking about the effectiveness of telehealth compared to in-person care. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for **each** statement. [Note: only respondents who currently use or discontinued use of audio-visual will only be shown audio-visual.]

7. Treatment Effectiveness: Audio-only and audio-visual telehealth technologies	Strongly agree	Agree	Disagree	Strongly disagree	I don't know
7a. Telehealth is effective for me to use in providing care to my patients.					
Audio-only					
Audio-visual					
7b. Telehealth fosters meaningful conversations with patients.					
Audio-only					
Audio-visual					
7c. Telehealth improves patient access to health care services compared to not having telehealth.					
Audio-only					
Audio-visual					
7d. Telehealth increases the frequency of follow-up visits, compared to not having telehealth.					
Audio-only					
Audio-visual					
7e. Telehealth is effective for monitoring adherence to treatment plans.					
Audio-only					
Audio-visual					

We would now like to know about your perceptions about the comparative effectiveness of telehealth **relative to in-person visits**. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for **each** statement. [Note: only respondents who currently use or discontinued use of audio-visual will only be shown audio-visual.]

8. Comparative Effectiveness: *Audio-only and audio-visual telehealth technologies in comparison to in-person*	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**I don't know**
8a. *For patients you have provided both telehealth and in-person visits:* telehealth visits are as good as in-person visits.					
Audio-only					
Audio-visual					
8b. *For patients you have provided both telehealth and in-person visits:* patients can communicate as effectively using telehealth compared to in-person visits.					
Audio-only					
Audio-visual					
8c. *For patients you have provided both telehealth and in-person visits:* telehealth gives patients more access to health care services compared to in-person visits.					
Audio-only					
Audio-visual					
8d. *For patients you have provided both telehealth and in-person visits:* telehealth is just as good as helping patients adhere to treatment plans as in-person visits.					
Audio-only					
Audio-visual					
8e. *For patients you have provided both telehealth and in-person visits:* use of telehealth limits my ability to maintain relationships with patients as compared to in-person visits.					
Audio-only					
Audio-visual					

Now we would like to know about your perceptions on how telehealth technologies have impacted care for different social groups. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for **each** statement.

9. Telehealth Equity: Please provide your responses to the following statements on access to telehealth for different underrepresented patient populations	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**I don't know**
9a. Patients with limited English language proficiency are less likely to use telehealth.					
Audio-only					
Audio-visual					
9b. Telehealth increases access to health care among populations who are vulnerable or underserved [see hover over below for definition below].					
Audio-only					
Audio-visual					
9c. Telehealth expands opportunities for people to obtain care from a provider of a specific race or gender who is not available nearby.					
Audio-only					
Audio-visual					
9d. Telehealth increases access to health care for patients with physical disabilities.					
Audio-only					
Audio-visual					
9e. Telehealth increases access to health care for patients with cognitive disabilities.					
Audio-only					
Audio-visual					
9f. Telehealth increases caregivers' ability to provide care for patients.					
Audio-only					
Audio-visual					
9g. Telehealth is a practical alternative when a patient lacks transportation [in non-emergency situations].					
Audio-only					
Audio-visual					
9h. Telehealth is a practical alternative for patients who would otherwise travel long distances for care.					
Audio-only					
Audio-visual					

Vulnerable populations refers to those who have poor access to health care, receive poor-quality care, and experience poor care outcomes — often resulting from societal injustices related to race, ethnicity, poverty, gender, sexual orientation, age, first language, or physical or mental health condition. **Underserved populations** refer to populations that do not have adequate access to medical care. This includes rural, elderly, low-literacy, blue collar, and poor populations. Minorities per se are not included, but often belong to one or more or the included categories. Similarly, people with special needs and homeless people also may belong to one or more of the included categories.

Now we would like to know the extent to which items/activities listed below are barriers. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for **each** statement.

10. Barriers to using: ***Audio-only and audio-visual telehealth technologies***	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**I don't know**
10a. Low commercial reimbursement for telehealth deters my use of telehealth.					
Audio-only					
Audio-visual					
10b. Low Medicare reimbursement for telehealth deters my use of telehealth.					
Audio-only					
Audio-visual					
10c. Low Medicaid reimbursement for telehealth deters my use of telehealth.					
Audio-only					
Audio-visual					
10d. Different payer rules for telehealth deter my use of telehealth.					
Audio-only					
Audio-visual					
10e. Telehealth reimbursement is more complicated than reimbursement for in-person visits, which deters my use of it.					
Audio-only					
Audio-visual					
10f. A lack of state regulations and best practices on how to keep patient information safe make it difficult to use telehealth.					
Audio-only					
Audio-visual					
10g. A lack of commercial reimbursement prevents me from using telehealth for patients with commercial coverage.					
Audio-only					
Audio-visual					
10h. My patients' concerns about privacy limit their use of telehealth.					
Audio-only					
Audio-visual					
10i. My patients' limited access to the internet or internet availability limits their use of audio-visual telehealth.					
Audio-visual					
10j. A lack of digital literacy among my patients reduces my ability to use telehealth with them. [Digital literacy is the ability to use and understand information from digital devices.]					

7

10. Barriers to using: *Audio-only and audio-visual telehealth technologies*	Strongly agree	Agree	Disagree	Strongly disagree	I don't know
Audio-visual					
10k. The limited availability of interpreters reduces my ability to use telehealth.					
Audio-only					
Audio-visual					
10l. Staff at my organization need more training on telehealth.					
Audio-only					
Audio-visual					

Now we would like to know about your perceptions of patient satisfaction with telehealth technologies and how it may vary for patients with different types of health care coverage. In the next set of questions, please report your perception of the extent to which patients with different types of health care coverage have reacted favorably to using telehealth. *[Note: Questions below based on responses to patient health care coverage in #5: if a form of coverage is <10%, the insurance type is not shown].*

11. Patient Satisfaction with Telehealth: *Audio-only and audio-visual telehealth technologies in comparison to in-person visits*	Very few (less than 10%)	Some, but less than half (10% to 25%)	Many but not most (26% to 50%)	Most (50% to 75%)	Nearly all (76% to 100%)	I don't see patients with this coverage
11a. Patients with Medicaid who have reacted favorably to telehealth services.						
Audio-only						
Audio-visual						
11b. Patients with Medicare who have reacted favorably to telehealth services.						
Audio-only						
Audio-visual						
11c. Patients with private insurance who have reacted favorably to telehealth services.						
Audio-only						
Audio-visual						
11d. Patients without insurance or who pay out-of-pocket who have reacted favorably to telehealth services.						
Audio-only						
Audio-visual						
11e. Patients with insurance status unknown who pay out-of-pocket payment.						
Audio-only						
Audio-visual						

Now we would like to know about your perceptions of your overall satisfaction with care delivery via telehealth. Please check a response category indicating if you strongly agree, agree, disagree, or strongly disagree, for **each** statement.

12. Overall Provider Satisfaction	Strongly agree	Agree	Disagree	Strongly disagree
12a. Use of telehealth improves my satisfaction with my work.				
Audio-only				
Audio-visual				
12b. I would like to increase the use of telehealth in my practice.				
Audio-only				
Audio-visual				

The End! Thank you for your time!

Appendix D: Provider Survey Response Tables

The target population of the survey included all somatic care providers engaged in primary care delivery and behavioral health care providers with a practice location in the State of Maryland. For purposes of this study, MHCC defined primary care as: 1) “somatic care” includes physical care delivered by primary care (general practice, internal medicine, and pediatrics) and specialty providers engaged in primary care, including nurse practitioners; and 2) “behavioral health care” includes care delivered by psychiatrists, psychologists, licensed certified social workers, and licensed professional counselors. The target population was derived from the Centers for Medicare and Medicaid Services National Plan and Provider Enumeration System (NPPES) file as of October 21, 2021.
Somatic care includes: Table I outlines the specialties corresponding to the four provider type classifications: 1) Allopathic & Osteopathic Physician Primary Care physicians (General Practice, Family Medicine, Internal Medicine, Pediatrics, Dermatology, Nurse Practitioners); 2) Specialists engaged in primary care (Allergy & Immunology, Clinical Pharmacology, Colon & Rectal Surgery, Independent Medical Examiner, Neuromusculoskeletal Medicine & OMM, Neuromusculoskeletal Medicine, Sports Medicine, Orthopedic Surgery, Otolaryngology, Pain Medicine, Physical Medicine & Rehabilitation, Preventive Medicine, Surgery, Thoracic Surgery Urology.

In collaboration with the MHCC, NORC assigned providers to one of four geographic regions: 1) Eastern Shore Region (Kent, Queen Anne’s, Talbot, Caroline, Dorchester, Wicomico, Somerset, Worchester, and Cecil County); 2) Western Maryland Region (Garrett, Allegany, Washington, and Frederick County) (3) Montgomery County and Prince George’s County, and (4) Central/Southern Maryland Region (Baltimore City, Baltimore County, Anne Arundel, Carroll Hartford, Howard, Calvert, Charles, and St. Mary’s County).

Exhibit 27. Provider Survey Response Tables

Q7. Treatment Effectiveness: Now we would like to know about your perceptions of the effectiveness of treatment delivered via telehealth.	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Telehealth is effective for me to use in providing care to my patients.														
Audio-only	24715	37	49	9	3	--	100	22287	31	56	7	--	--	100
Audio-visual	25053	72	25	2	--	--	100	28995	83	16	--	--	--	100
Telehealth fosters meaningful conversations with patients.														
Audio-only	24574	50	43	5	--	2	100	22342	46	45	6	--	--	100
Audio-visual	24957	74	24	--	--	--	100	28995	84	14	--	--	--	100
Telehealth improves patient access to health care services compared to not having telehealth.														
Audio-only	24669	75	21	2	--	--	100	22342	84	13	--	--	--	100
Audio-visual	25021	86	13	--	--	--	100	28852	91	9	--	--	--	100
Telehealth increases the frequency of follow-up services, compared to not having telehealth.														
Audio-only	24592	60	22	11	3	5	100	22141	72	15	5	--	6	100
Audio-visual	24804	64	21	9	3	3	100	28828	76	15	4	--	4	100
Telehealth is effective for monitoring adherence to treatment plans.														
Audio-only	24669	60	34	4	--	--	100	22141	56	35	5	--	4	100
Audio-visual	24835	70	26	2	--	--	100	28828	74	21	--	--	--	100

Q7. Treatment Effectiveness: Now we would like to know about your perceptions of the effectiveness of treatment delivered via telehealth.	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Telehealth is effective for me to use in providing care to my patients.																								
Audio-only	3031	38	50	--	--	--	13618	37	50	--	--	--	26933	32	54	11	2	2	3419	36	56	--	--	--
Audio-visual	3351	89	--	--	--	--	16066	81	18	--	--	--	30924	75	23	2	--	--	3708	83	--	--	--	--
Telehealth fosters meaningful conversations with patients.																								
Audio-only	3031	49	46	--	--	--	13618	55	38	--	--	--	26957	44	47	6	--	2	3310	52	41	--	--	--
Audio-visual	3351	87	--	--	--	--	16143	85	13	--	--	--	30860	76	23	--	--	--	3598	81	--	--	--	--
Telehealth improves patient access to health care services compared to not having telehealth.																								
Audio-only	3031	86	--	--	--	--	13618	82	18	--	--	--	27052	77	19	2	--	--	3310	88	--	--	--	--
Audio-visual	3351	95	--	--	--	--	15977	90	9	--	--	--	30837	86	13	--	--	--	3708	97	--	--	--	--
Telehealth increases the frequency of follow-up services, compared to not having telehealth.																								
Audio-only	3031	71	--	--	--	--	13452	67	17	7	--	--	26997	63	21	9	2	6	3252	76	--	--	--	--
Audio-visual	3351	79	--	--	--	--	15989	74	14	--	--	--	30751	68	21	7	2	3	3541	78	--	--	--	--
Telehealth is effective for monitoring adherence to treatment plans.																								
Audio-only	3031	68	--	--	--	--	13529	61	33	--	--	--	26997	55	36	5	--	3	3252	58	31	--	--	--
Audio-visual	3351	84	--	--	--	--	15989	74	22	--	--	--	30782	69	26	3	--	2	3541	79	--	--	--	--

Q8. Comparative Effectiveness: Audio-only and audio-visual telehealth technologies in comparison to in-person. For patients you have provided both telehealth and in-person services	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Telehealth services are as good as in-person services.														
Audio-only	24585	11	34	37	13	5	100	22074	19	38	31	8	4	100
Audio-visual	25021	22	43	26	6	3	100	28886	51	36	8	--	3	100
Patients can communicate as effectively using telehealth compared to in-person services.														
Audio-only	24699	35	42	18	3	3	100	22055	33	47	15	3	--	100
Audio-visual	25021	47	40	9	2	--	100	28763	62	31	5	--	--	100
Telehealth gives patients more access to health care services compared to in-person services.														
Audio-only	24669	54	29	12	2	3	100	22019	75	17	4	--	4	100
Audio-visual	24912	60	27	10	--	--	100	28763	81	13	3	--	3	100
Telehealth is just as good as helping patients adhere to treatment plans as in-person services.														
Audio-only	24638	40	38	16		4	100	22287	41	40	12	--	6	100
Audio-visual	25021	53	32	11	--	3	100	28763	65	26	4	--	4	100
Use of telehealth limits my ability to maintain relationships with patients as compared to in-person services.														
Audio-only	24574	11	24	43	19	3	100	22287	10	20	37	26	6	100
Audio-visual	24894	8	19	43	29	--	100	28907	7	12	31	48	--	100

Q8. Comparative Effectiveness: Audio-only and audio-visual telehealth technologies in comparison to in-person. For patients you have provided both telehealth and in-person services	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Telehealth services are as good as in-person services.																								
Audio-only	2855	--	32	36	--	-	13529	18	39	30	9	--	26965	13	32	38	12	5	3310	--	53	24	--	--
Audio-visual	3351	49	36	--	--	--	16143	44	37	14	--	--	30814	33	40	19	4	4	3598	40	41	--	--	--
Patients can communicate as effectively using telehealth compared to in-person services.																								
Audio-only	3031	36	41	--	--	--	13440	39	41	14	--	--	26942	31	46	18	3	2	3310	37	46	--	--	--
Audio-visual	3351	59	37	--	--	--	15965	59	32	6	--	--	30869	52	37	8	2	2	3598	64	30	--	--	--
Telehealth gives patients more access to health care services compared to in-person services.																								
Audio-only	2907	66	--	--	--	--	13529	62	25	8	--	--	26942	62	25	8	2	3	3310	80	--	--	--	--
Audio-visual	3351	79	--	--	--	--	15888	72	18	7	--	--	30837	69	22	6	--	2	3598	85	--	--	--	--
Telehealth is just as good as helping patients adhere to treatment plans as in-person services.																								
Audio-only	3031	40	40	--	--	--	13618	43	40	10	--	--	26965	39	39	15	3	5	3310	49	29	--	--	--
Audio-visual	3351	60	31	--	--	--	15965	64	27	6	--	--	30869	56	31	8	2	4	3598	70	--	--	--	--
Use of telehealth limits my ability to maintain relationships with patients as compared to in-person services.																								
Audio-only	3031	--	26	34	--	--	13618	11	24	35	23	--	26902	12	22	42	21	4	3310	--	--	56	--	--
Audio-visual	3351	--	20	29	46	--	16054	9	15	31	43	--	30797	7	15	39	36	2	3598	--	--	48	36	--

Q9. Now we would like to know about your perceptions on how telehealth technologies have impacted care for different social groups. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for each statement.	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Strongly	Agree	Disagree	Strongly	Don't	Total	Weighted N	Strongly	Agree	Disagree	Strongly	Don't	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Patients with limited English language proficiency are less likely to use telehealth.														
Audio-only	24561	19	36	19	5	20	100	22376	6	14	17	10	53	100
Audio-visual	25129	17	34	22	6	20	100	28995	3	15	19	12	52	100
Telehealth increases access to health care among populations who are vulnerable or underserved.														
Audio-only	24669	53	34	5	--	8	100	22431	68	22	--	--	7	100
Audio-visual	25129	48	37	7	--	6	100	28995	67	23	3	--	7	100
Telehealth expands opportunities for people to obtain care from a provider of a specific race or gender who is not available nearby.														
Audio-only	24638	42	26	3	--	27	100	22431	59	22	--	--	17	100
Audio-visual	25002	43	26	3	--	26	100	28995	64	20	--	--	15	100
Telehealth increases access to health care for patients with physical disabilities.														
Audio-only	24669	68	27	--	--	3	100	22342	80	15	--	--	4	100
Audio-visual	25098	70	27	--	--	3	100	28995	84	12	--	--	3	100
Telehealth increases access to health care for patients with cognitive disabilities.														
Audio-only	24638	32	29	17	--	20	100	22129	31	28	9	--	30	100
Audio-visual	25098	34	30	15	2	19	100	28907	35	26	7	--	30	100
Telehealth increases caregivers' ability to provide care for patients.														
Audio-only	24542	58	35	2	--	5	100	22431	58	26	3	--	13	100
Audio-visual	25002	65	29	--	--	4	100	28941	61	25	--	--	11	100
Telehealth is a practical alternative when a patient lacks transportation [in non-emergency situations].														
Audio-only	24606	73	24	--	--	--	100	22431	85	13	--	--	--	100
Audio-visual	25034	79	20	--	--	--	100	28995	91	9	--	--	--	100
Telehealth is a practical alternative for patients who would otherwise travel long distances for care.														
Audio-only	24606	74	22	3	--	--	100	22342	86	11	--	--	--	100
Audio-visual	25034	78	20	--	--	--	100	28852	91	8	--	--	--	100

Q9. Now we would like to know about your perceptions on how telehealth technologies have impacted care for different social groups. Please check a response category indicating if you strongly agree, agree, disagree, strongly disagree, or don't know for each statement.	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Patients with limited English language proficiency are less likely to use telehealth.																								
Audio-only	3031	--	--	--	--	43	13630	13	23	18	7	39	26965	12	29	20	7	33	3310	--	--	--	--	40
Audio-visual	3351	--	--	--	--	44	16220	9	22	18	7	45	30956	10	26	23	9	32	3598	--	--	--	--	36
Telehealth increases access to health care among populations who are vulnerable or underserved.																								
Audio-only	3031	64	--	--	--	--	13707	62	25	--	--	9	27052	58	30	4	--	7	3310	65	--	--	--	--
Audio-visual	3351	74	--	--	--	--	16220	61	25	--	--	9	30956	55	33	5	--	6	3598	57	36	--	--	--
Telehealth expands opportunities for people to obtain care from a provider of a specific race or gender who is not available nearby.																								
Audio-only	3031	61	--	--	--	--	13707	56	24	--	--	19	27020	46	25	3	--	25	3310	53	--	--	--	--
Audio-visual	3351	68	--	--	--	--	16220	61	22	--	--	15	30829	49	25	2	--	23	3598	55	--	--	--	--
Telehealth increases access to health care for patients with physical disabilities.																								
Audio-only	3031	71	--	--	--	--	13618	80	17	--	--	--	27052	70	25	--	--	4	3310	81	--	--	--	--
Audio-visual	3351	84	--	--	--	--	16220	82	15	--	--	--	30924	74	23	--	--	3	3598	83	--	--	--	--
Telehealth increases access to health care for patients with cognitive disabilities.																								
Audio-only	2907	--	29	--	--	--	13529	31	25	15	--	28	27020	31	30	13	2	24	3310	46	--	--	--	--
Audio-visual	3351	34	31	--	--	--	16131	32	27	11	--	28	30924	35	29	10	2	24	3598	46	26	--	--	--
Telehealth increases caregivers' ability to provide care for patients.																								
Audio-only	3031	50	25	--	--	--	13707	61	29	--	--	9	26925	56	33	4	--	7	3310	71	--	--	--	--
Audio-visual	3351	65	--	--	--	--	16220	63	26	--	--	8	30774	61	30	2	--	7	3598	72	--	--	--	--
Telehealth is a practical alternative when a patient lacks transportation [in non-emergency situations].																								
Audio-only	3031	84	--	--	--	--	13707	80	17	--	--	--	26988	77	20	2	--	--	3310	81	--	--	--	--
Audio-visual	3351	92	--	--	--	--	16220	86	13	--	--	--	30860	84	15	--	--	--	3598	83	--	--	--	--
Telehealth is a practical alternative for patients who would otherwise travel long distances for care.																								
Audio-only	3031	79	--	--	--	--	13618	82	14	--	--	--	26988	78	19	2	--	--	3310	85	--	--	--	--
Audio-visual	3351	87	--	--	--	--	161131	86	12	--	--	--	30806	84	15	--	--	--	3598	88	--	--	--	--

Q10. Now we would like to know the extent to which items/activities listed below are barriers.	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Low commercial reimbursement for telehealth deters my use of telehealth.														
Audio-only	24606	37	23	19	6	15	100	22431	23	21	19	9	29	100
Audio-visual	25034	20	27	28	8	17	100	28941	14	20	26	13	27	100
Low Medicare reimbursement for telehealth deters my use of telehealth.														
Audio-only	24465	30	22	22	6	19	100	22287	15	16	22	6	40	100
Audio-visual	24894	19	24	29	8	21	100	28742	12	13	25	9	42	100
Low Medicaid reimbursement for telehealth deters my use of telehealth.														
Audio-only	24434	28	24	19	7	22	100	22198	18	14	19	9	40	100
Audio-visual	24817	19	25	26	8	23	100	28708	14	11	22	10	43	100
Different payer rules for telehealth deter my use of telehealth.														
Audio-only	24402	28	29	19	6	18	100	22232	20	26	18	9	27	100
Audio-visual	24894	23	30	22	7	18	100	28632	18	26	20	11	26	100
Telehealth reimbursement is more complicated than reimbursement for in-person services, which deters my use of it.														
Audio-only	24402	16	18	27	9	29	100	22376	11	12	25	10	42	100
Audio-visual	24735	14	18	30	9	30	100	28797	8	11	27	13	41	100
A lack of state regulations and best practices on how to keep patient information safe make it difficult to use telehealth.														
Audio-only	24402	7	15	46	21	11	100	22321	4	8	46	33	9	100
Audio-visual	24817	6	14	48	22	10	100	28797	3	11	46	32	9	100
A lack of commercial reimbursement prevents me from using telehealth for patients with commercial coverage.														
Audio-only	24402	21	25	27	9	18	100	22287	14	15	29	12	31	100
Audio-visual	24810	15	23	32	11	19	100	28598	11	15	29	15	29	100
My patients' concerns about privacy limit their use of telehealth.														
Audio-only	24434	--	5	47	39	8	100	22376	--	6	38	50	4	100
Audio-visual	24862	--	6	47	39	7	100	28708	--	8	37	50	--	100
My patients' limited access to the internet or internet availability limits their use of audio-visual telehealth.														
Audio-visual	24939	25	46	20	6	3	100	28674	14	32	33	20	--	100
A lack of digital literacy among my patients reduces my ability to use telehealth with them. [Digital literacy is the ability to use and understand information from digital devices.]														
Audio-visual	25560	22	48	22	7	3	100	29009	8	30	39	21	--	100
The limited availability of interpreters reduces my ability to use telehealth.														
Audio-only	24146	12	24	39	9	17	100	21745	3	8	32	17	40	100
Audio-visual	24581	10	23	42	10	15	100	28475	4	7	32	19	38	100
Staff at my organization need more training on telehealth.														
Audio-only	24350	6	17	50	23	5	100	22123	--	10	45	28	16	100
Audio-visual	24940	6	19	50	21	4	100	28619	--	11	44	31	13	100

Q10. Now we would like to know the extent to which items/activities listed below are barriers.	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Low commercial reimbursement for telehealth deters my use of telehealth.																								
Audio-only	3031	--	--	27	--	--	13707	37	23	12	--	21	26988	27	24	22	7	21	3310	--	--	--	--	29
Audio-visual	3351	--	--	37	--	--	16220	20	26	21	12	21	30806	14	25	30	10	21	3598	--	--	--	--	34
Low Medicare reimbursement for telehealth deters my use of telehealth.																								
Audio-only	3031	--	--	37	--	--	13541	28	22	16	--	29	26870	21	20	24	6	30	3310	--	--	24	--	32
Audio-visual	3351	--	--	32	--	--	16054	18	19	20	7	36	30632	13	19	30	8	30	3598	--	--	24	--	35
Low Medicaid reimbursement for telehealth deters my use of telehealth.																								
Audio-only	3031	--	--	35	--	--	13452	28	20	10	--	37	26838	22	21	22	8	28	3310	--	--	--	--	38
Audio-visual	3351	--	--	39	--	--	15888	18	18	15	--	45	30687	15	19	27	10	29	3598	--	--	--	--	38
Different payer rules for telehealth deter my use of telehealth.																								
Audio-only	3031	--	--	27	--	--	13541	31	29	16	--	19	26752	20	28	20	8	24	3310	--	--	--	--	--
Audio-visual	3351	--	--	31	--	--	16054	24	30	17	9	20	30523	17	28	23	9	23	3598	--	21	--	--	25
Telehealth reimbursement is more complicated than reimbursement for in-person services, which deters my use of it.																								
Audio-only	3031	--	--	28	--	38	13630	18	13	28	10	31	26806	12	16	27	8	38	3310	--	--	--	--	34
Audio-visual	3351	--	--	--	--	42	16054	13	12	31	13	31	30529	10	15	28	10	38	3598	--	--	22	--	35
A lack of state regulations and best practices on how to keep patient information safe make it difficult to use telehealth.																								
Audio-only	3031	--	--	51	--	--	13630	8	16	38	29	8	26752	4	11	51	24	10	3310	--	--	36	34	--
Audio-visual	3351	--	--	50	32	--	15977	7	14	40	31	8	30687	4	12	51	24	10	3598	--	--	36	35	--
A lack of commercial reimbursement prevents me from using telehealth for patients with commercial coverage.																								
Audio-only	3031	--	--	35	--	--	13541	24	21	22	12	21	26806	14	20	31	9	27	3310	--	--	--	--	--
Audio-visual	3298	--	--	33	--	--	15965	17	20	26	16	21	30546	10	18	35	11	26	3598	--	--	--	--	--
My patients' concerns about privacy limit their use of telehealth.																								
Audio-only	3031	--	--	37	38	--	13630	--	--	39	44	9	26838	--	4	47	43	6	3310	--	--	34	52	--
Audio-visual	3351	--	--	41	39	--	15965	--	7	36	49	6	30655	2	5	46	43	4	3598	--	--	31	51	--
My patients' limited access to the internet or internet availability limits their use of audio-visual telehealth.																								
Audio-visual	3351	31	41	--	--	--	15953	14	37	26	18	--	30710	19	39	30	11	2	3598	--	42	--	--	--

Q10. Now we would like to know the extent to which items/activities listed below are barriers.	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
A lack of digital literacy among my patients reduces my ability to use telehealth with them. [Digital literacy is the ability to use and understand information from digital devices.]																								
Audio-visual	3456	--	42	--	--	--	16184	13	34	32	20	--	31215	15	39	31	12	3	3714	--	48	--	--	3456
The limited availability of interpreters reduces my ability to use telehealth.																								
Audio-only	2855	--	--	--	--	38	13376	10	12	34	11	33	26350	7	19	38	12	23	3310	--	--	30	--	31
Audio-visual	3351	--	--	35	--	35	15634	7	11	34	13	35	30474	7	17	40	14	23	3598	--	--	31	24	28
Staff at my organization need more training on telehealth.																								
Audio-only	2979	--	--	41	--	--	13464	--	10	41	33	12	26610	4	15	51	20	10	3419	--	--	48	33	--
Audio-visual	3351	--	--	49	--	--	15876	--	9	40	35	13	30624	4	18	49	21	8	3708	--	--	49	30	--

Q11. Please report your perception of the extent to which patients with different types of health care coverage have reacted favorably to using telehealth. [Note: Questions below based on responses to patient health care coverage: if a form of coverage is <10%, the insurance type is not shown].	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)	Total	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Patients with Medicaid who have reacted favorably to telehealth services.														
Audio-only	17731	6	7	12	36	39	100	13084	--	--	7	26	61	100
Audio-visual	18155	--	6	10	38	44	100	16675	--	--	5	26	67	100
Patients with Medicare who have reacted favorably to telehealth services.														
Audio-only	20302	3	7	14	34	42	100	11649	--	--	11	23	60	100
Audio-visual	20310	--	8	12	34	44	100	12845	--	--	7	24	65	100
Patients with private insurance who have reacted favorably to telehealth services.														
Audio-only	22633	3	4	11	33	49	100	15602	--	--	6	23	64	100
Audio-visual	23405	--	3	10	29	57	100	20925	--	--	5	18	76	100
Patients without insurance or who pay out-of-pocket who have reacted favorably to telehealth services.														
Audio-only	2965	17	--	--	23	36	100	2218	--	--	--	--	72	100
Audio-visual	2825	--	--	--	27	33	100	2759	--	--	--	--	76	100
Patients with insurance status unknown who pay out-of-pocket payment.														
Audio-only	1533	--	--	--	--	--	100	5630	--	--	--	20	74	100
Audio-visual	1411	--	--	--	--	44	100	7786	--	--	--	11	85	100

Q11. Please report your perception of the extent to which patients with different types of health care coverage have reacted favorably to using telehealth. [Note: Questions below based on responses to patient health care coverage: if a form of coverage is <10%, the insurance type is not shown].	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)	Weighted N	Very Few (less than 10%)	Some, but less than half (10-25%)	Many, but not most (26-50%)	Most (51-75%)	Nearly all (76-100%)
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Patients with Medicaid who have reacted favorably to telehealth services.																								
Audio-only	2239	--	--	--	--	61	6419	--	--	--	31	50	19919	3	5	13	33	45	2239	--	--	--	--	58
Audio-visual	2682	--	--	--	--	57	7307	--	--	--	36	55	22370	--	4	10	32	53	2470	--	--	--	--	69
Patients with Medicare who have reacted favorably to telehealth visits.																								
Audio-only	2659	--	--	--	40	50	9188	--	--	13	27	52	17877	3	5	14	31	46	2226	--	--	--	--	55
Audio-visual	2678	--	--	--	--	51	9467	--	--	12	30	52	18726	--	7	11	30	52	2284	--	--	--	--	54
Patients with private insurance who have reacted favorably to telehealth visits.																								
Audio-only	2731	--	--	--	33	55	10680	--	--	9	25	59	22040	3	4	9	32	51	2784	--	--	--	--	66
Audio-visual	3050	--	--	--	--	59	12547	--	--	--	19	72	25718	--	2	8	27	63	3015	--	--	--	--	72
Patients without insurance or who pay out-of-pocket who have reacted favorably to telehealth visits.																								
Audio-only	439	--	--	--	--	--	1710	--	--	--	--	--	2802	--	--	--	31	50	231	--	--	--	--	--
Audio-visual	439	--	--	--	--	--	1900	--	--	--	--	--	3013	--	--	--	29	50	231	--	--	--	--	--
Patients with insurance status unknown who pay out-of-pocket payment.																								
Audio-only	177	--	--	--	--	--	3346	--	--	--	--	73	3127	--	--	--	26	61	513	--	--	--	--	--
Audio-visual	177	--	--	--	--	--	4526	--	--	--	--	81	3982	--	--	--	16	75	513	--	--	--	--	--

Q12. Now we would like to know about your perceptions of your overall satisfaction with care delivery via telehealth. Please check a response category indicating if you strongly agree, agree, disagree, or strongly disagree, for each statement.	Somatic Health Care Providers							Behavioral Health						
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Total
	N	%	%	%	%	%	%	N	%	%	%	%	%	%
Use of telehealth improves my satisfaction with my work.														
Audio-only	24384	38	37	19	6		100	22177	42	36.7	16	5		100
Audio-visual	24876	46	38	12	5		100	28708	62	26.4	10	--		100
I would like to increase the use of telehealth in my practice.														
Audio-only	24307	38	31	26	5		100	21945	37	31.3	26	5		100
Audio-visual	24876	45	34	19	3		100	28598	56	28.8	13	--		100

Q12. Now we would like to know about your perceptions of your overall satisfaction with care delivery via telehealth. Please check a response category indicating if you strongly agree, agree, disagree, or strongly disagree, for each statement.	Eastern						National Capital Area						South-Central						Western					
	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	Weighted N	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%	N	%	%	%	%	%
Use of telehealth improves my satisfaction with my work.																								
Audio-only	3031	50	39	--	--		13541	42	38	14	--		26570	37	37	19	6		3419	46	31	--	--	
Audio-visual	3351	70	25	--	--		15965	57	27	12	--		30560	50	35	11	4		3708	60	33	--	--	
I would like to increase the use of telehealth in my practice.																								
Audio-only	3031	28	46	--	--		13287	43	29	23	--		26515	36	31	27	6		3419	41	31	--	--	
Audio-visual	3351	52	37	--	--		15965	56	27	14	--		30451	48	33	17	3		3708	58	27	--	--	

Appendix E: Claims Analysis Table

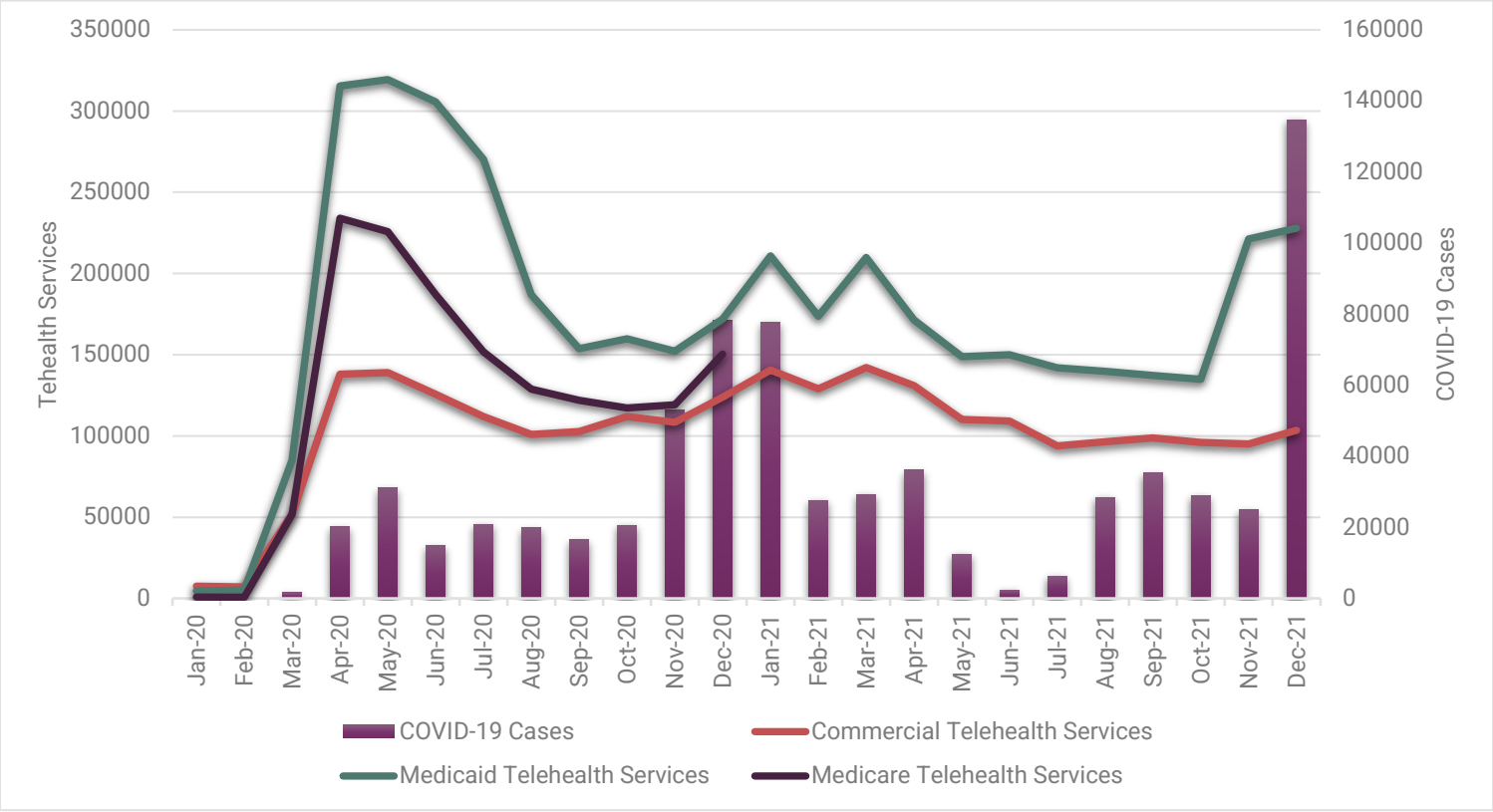
Appendix E contains additional descriptive analyses of trends of telehealth services from January 2020 through December 2021 in commercial, Medicaid, and Medicare populations. All analyses provided below provide additional evidence of trends described above in the utilization section of the report. The additional exhibits below are organized into seven major sections:

1. Trends in E&M telehealth services per month for commercial, Medicaid and Medicare populations by type of care (somatic care vs. behavioral care).
2. Trends in E&M telehealth services per month for commercial, Medicaid, and Medicare populations by provider type (primary/specialty care provider vs. behavioral health provider).
3. Proportion of E&M telehealth services per month for commercial, Medicaid, and Medicare populations by type of care (somatic care vs. behavioral care).
4. Proportion of E&M telehealth services per month for commercial, Medicaid, and Medicare populations by provider type (primary/specialty care provider vs. behavioral health provider).
5. Proportion of providers with at least one E&M telehealth service servicing commercial, Medicaid, and Medicare populations.
6. Analyses for sub-populations presented for commercial, Medicaid, and Medicare populations separately, for a total of three graphs for each sub-population.
    a. Proportion of E&M telehealth services by gender.
    b. Proportion of E&M telehealth services by age group.
    c. Proportion of E&M telehealth services by urban and rural locality.
    d. Proportion of E&M telehealth services by zip code with high versus low levels of disadvantage.
    e. Percent of unique beneficiaries with at least one E&M service, and at least E&M telehealth service.
    f. Percent of beneficiaries with at least one E&M service, and at least one E&M telehealth service by gender.
    g. Percent of beneficiaries with at least one E&M service, and at least one E&M telehealth service by urban and rural location.
    h. Percent of beneficiaries with at least one E&M service, and at least one E&M telehealth service by zip code with high versus low levels of disadvantage.
7. Exhibits for beneficiaries with at least one service per month

Exhibits on the Trends in E&M telehealth services per month for commercial, Medicaid and Medicare populations by type of care (somatic care vs. behavioral care).

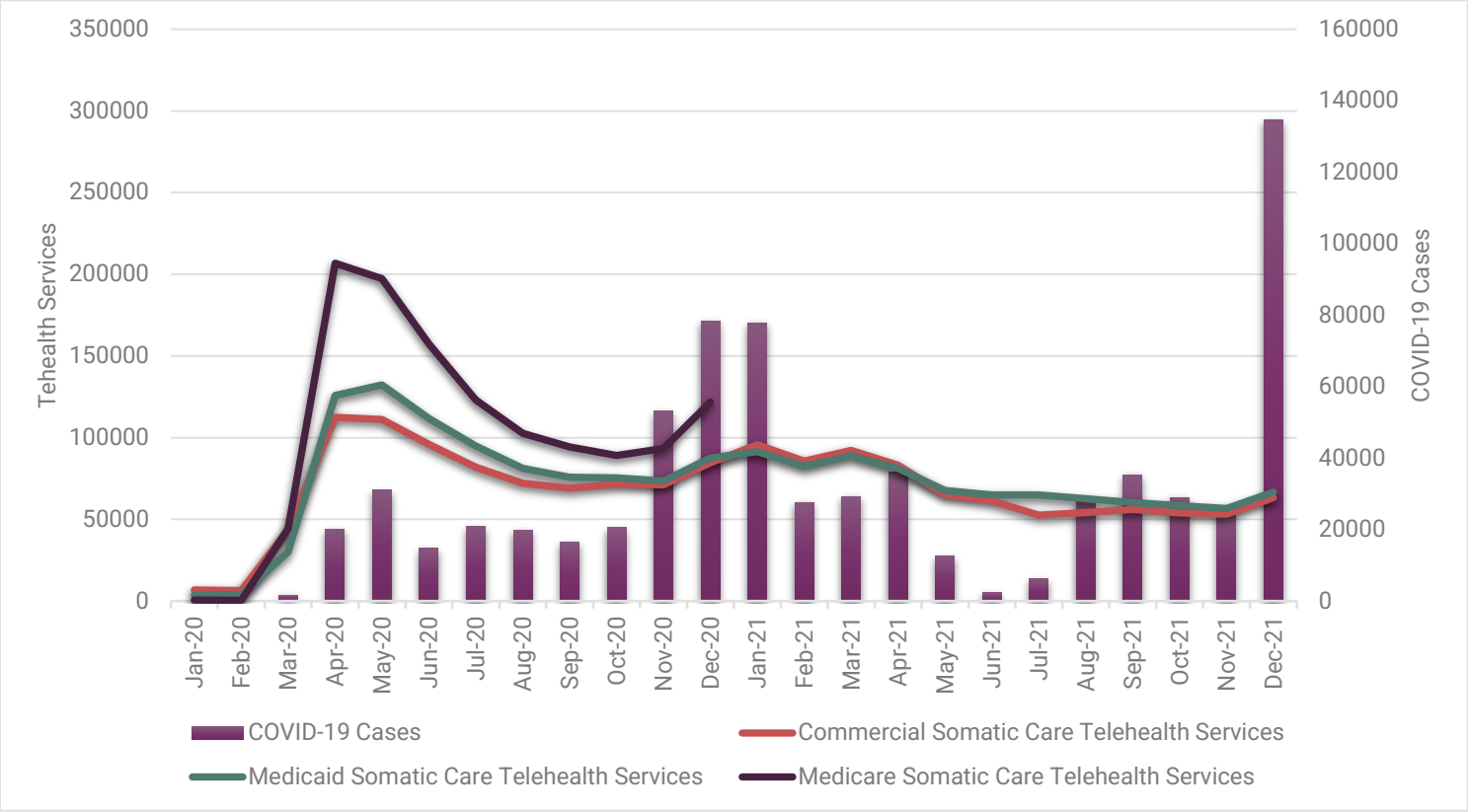
Similar patterns are seen in the following three exhibits as discussed in the technical report. The number of telehealth E&M services rapidly increased after the start of the PHE, peaking in April of 2020. Telehealth services for commercial, Medicaid, and Medicare began to slowly stabilize through the end of the analytic period.

Number of Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, all E&M services



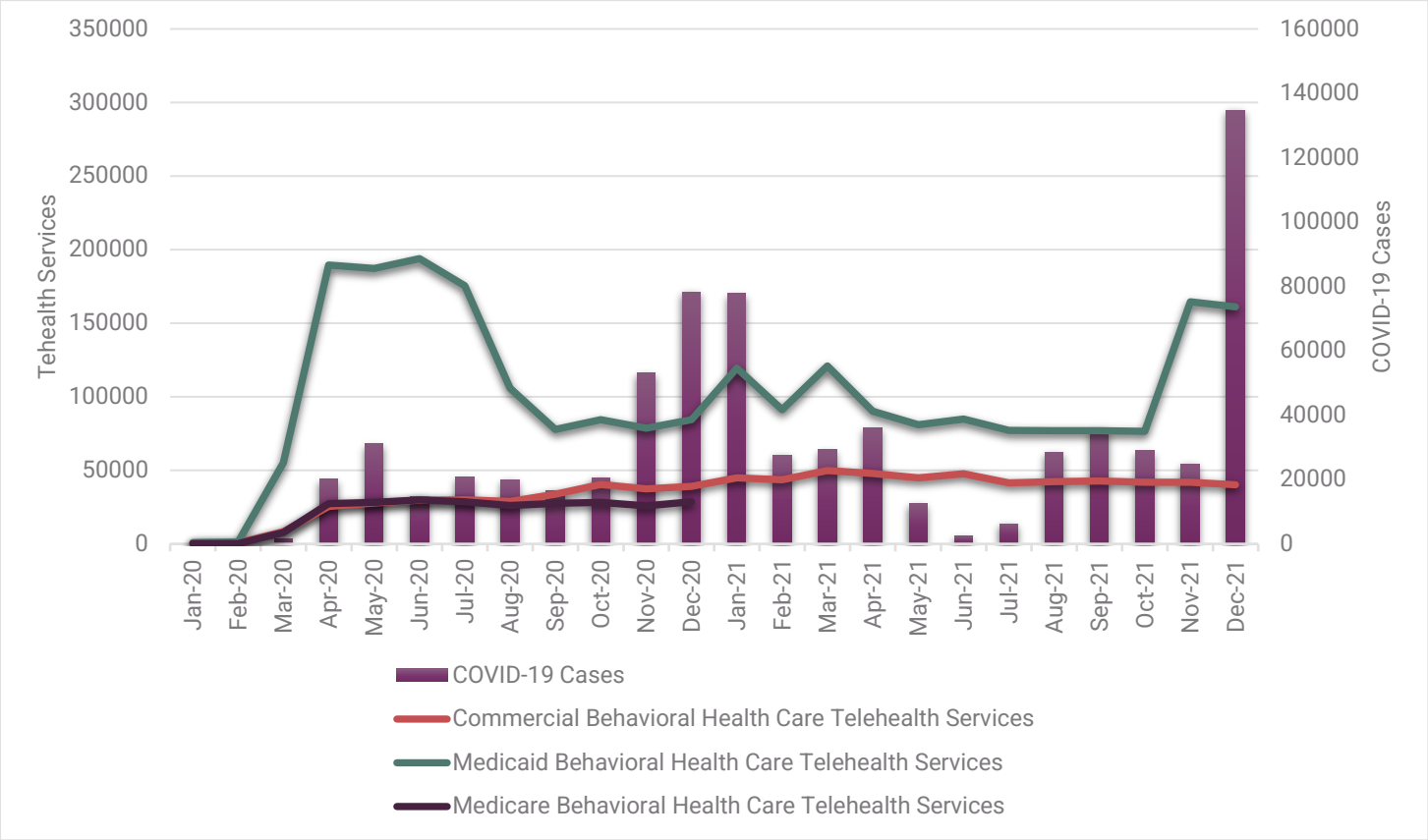
Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the monthly number of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Number of Somatic Care Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, somatic E&M services



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the monthly number of somatic care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Somatic services were defined by BETOS subgroup codes EC, EE, EH, EI, EM, EN, EO, ER, EV, EX.

Number of Behavioral Health Care Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, behavioral E&M services

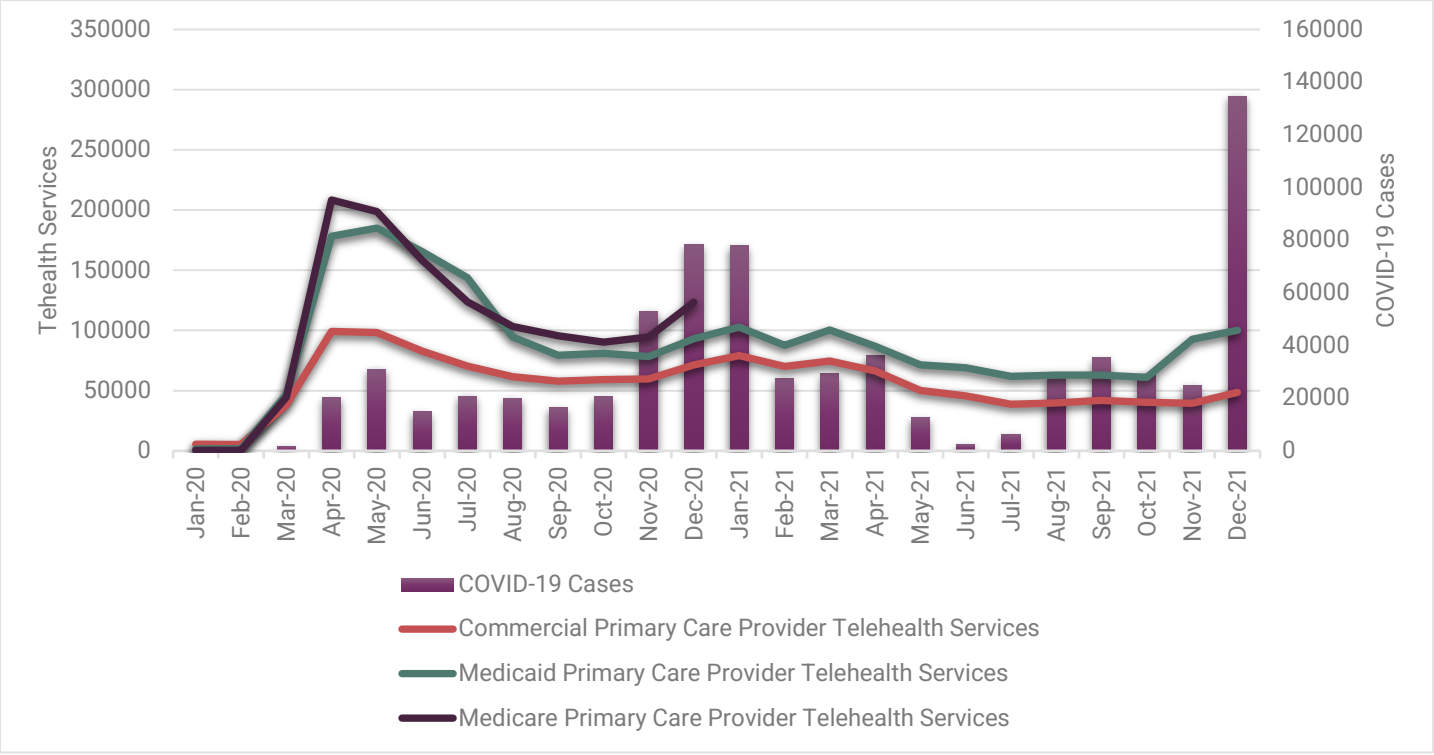


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the monthly number of behavioral health care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Behavioral services were defined by BETOS subgroup code EB.

Exhibits for the Trends in E&M telehealth services per month for commercial, Medicaid, and Medicare populations by provider type (primary/specialty care provider vs. behavioral health provider.

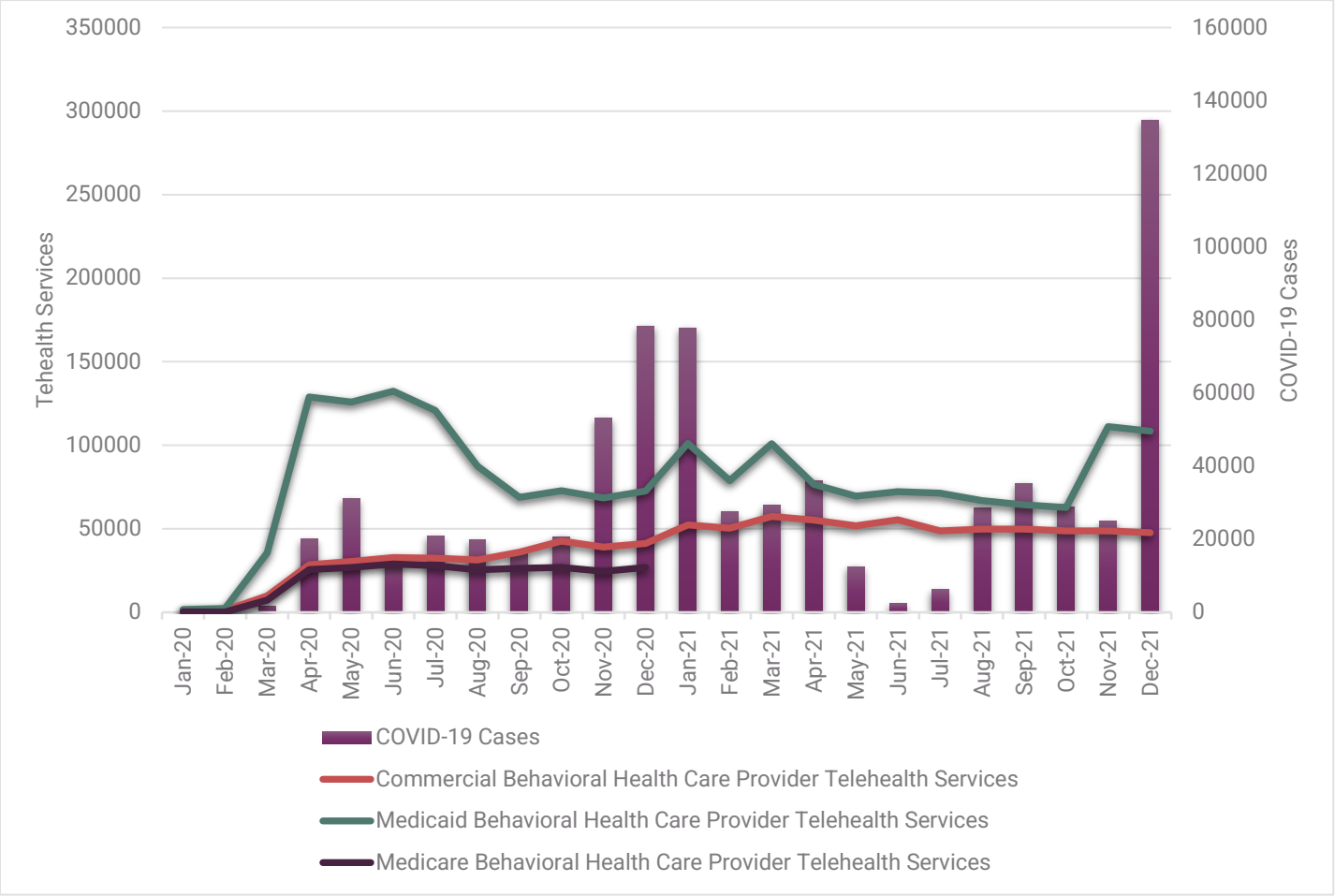
Overall, patterns are similar for the number of telehealth E&M services provided by primary care and specialty providers over the analytic period. A rapid uptake was seen in the use of telehealth to provide E&M services during the beginning of the PHE, with the number of services dropping and stabilizing across all payors through the end of 2021. However, the number behavioral health E&M services provided through telehealth technologies was highest for Medicaid providers, compared to Medicare and commercial providers. The pattern continued throughout the analytic period.

Number of Telehealth Services by Primary Care Providers per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, E&M services furnished by primary care and specialty care providers



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the monthly number of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Provider type was identified through specialty. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider types were identified using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and NUCC crosswalks.

Number of Telehealth Services by Behavioral Health Care Providers per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, services furnished by behavioral health care providers

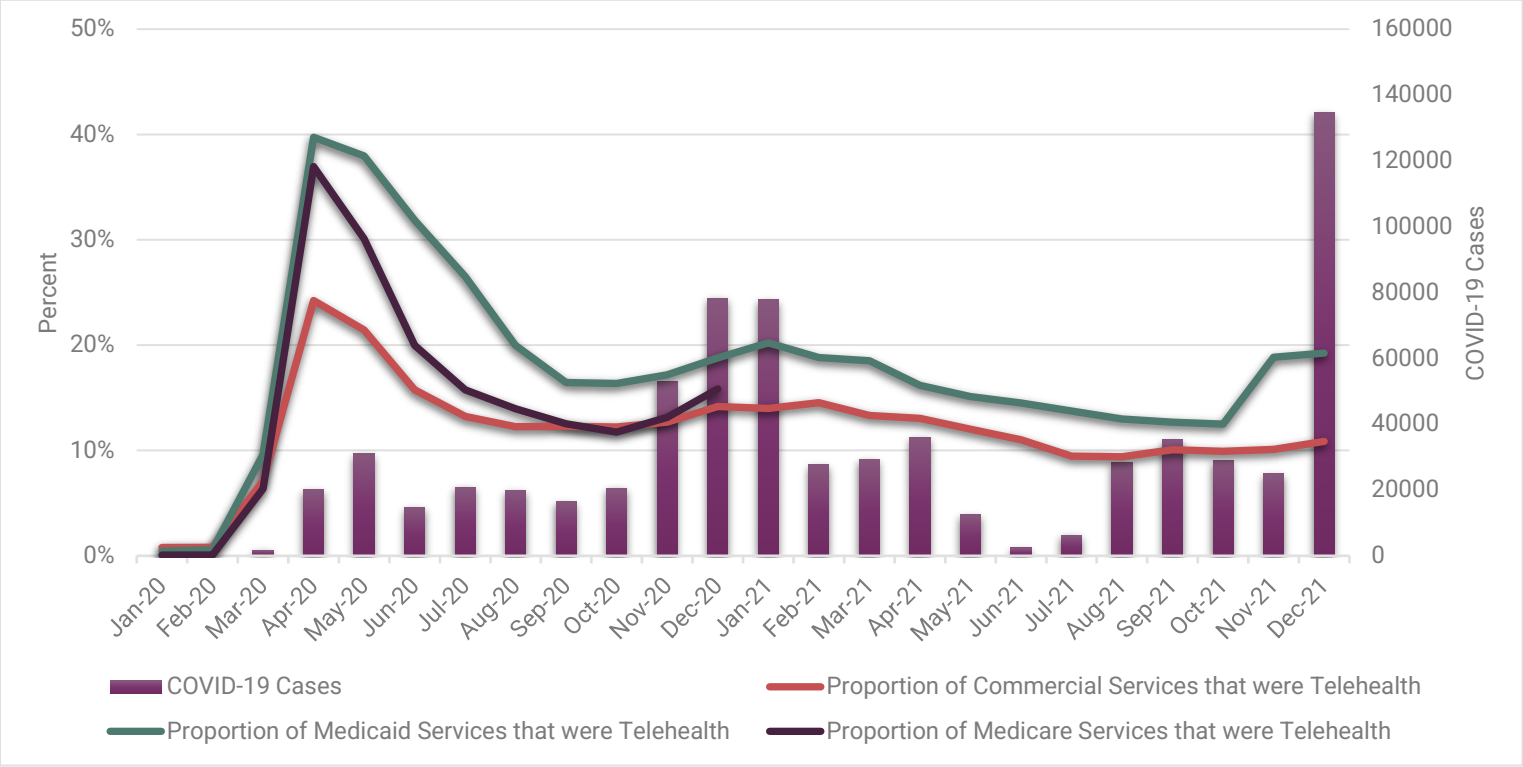


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the monthly number of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Provider type was identified through specialty. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider type assignment were made using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and crosswalks.

Exhibits for the Proportion of E&M telehealth services per month for commercial, Medicaid, and Medicare populations by type of care (somatic care vs. behavioral care.

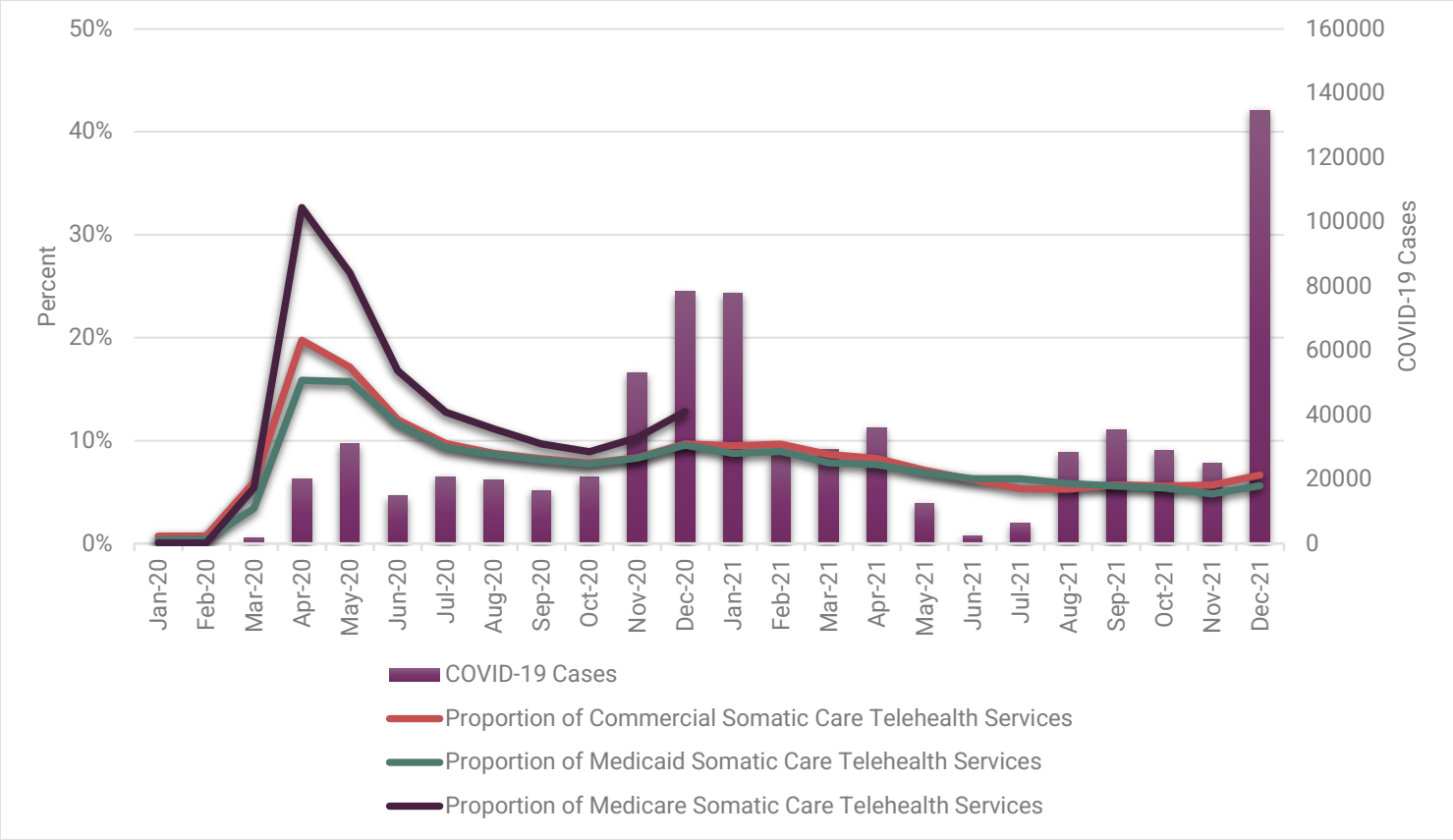
Similar to the patterns discussed in the technical report, the proportion of E&M telehealth services stabilized at a substantially higher level than pre-PHE.

Proportion of Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, all E&M services



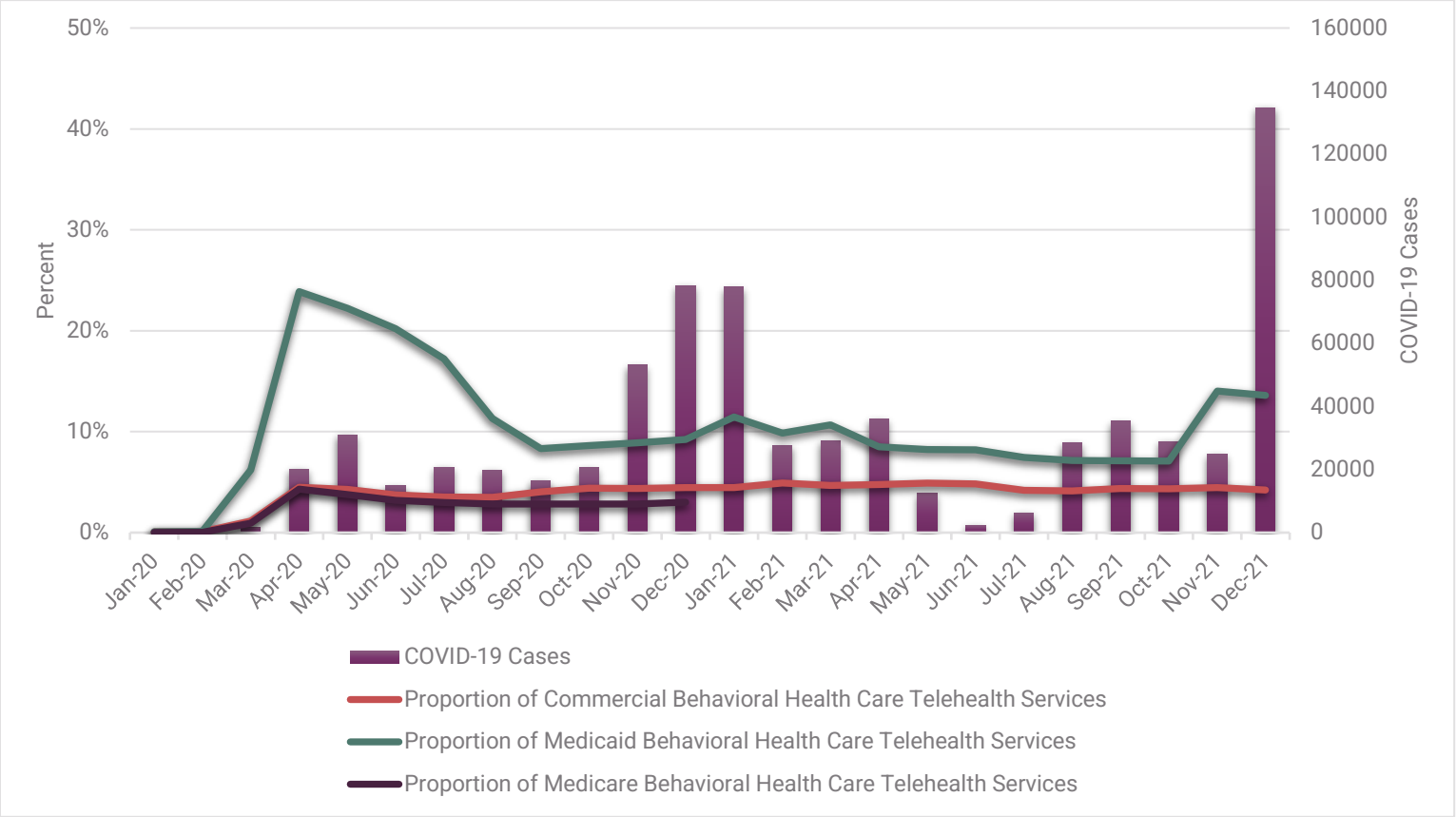
Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Proportion of Somatic Care Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, somatic E&M services



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of somatic care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Somatic services were defined by BETOS subgroup codes EC, EE, EH, EI, EM, EN, EO, ER, EV, EX.

Proportion of Behavioral Health Care Telehealth Services per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, behavioral E&M services

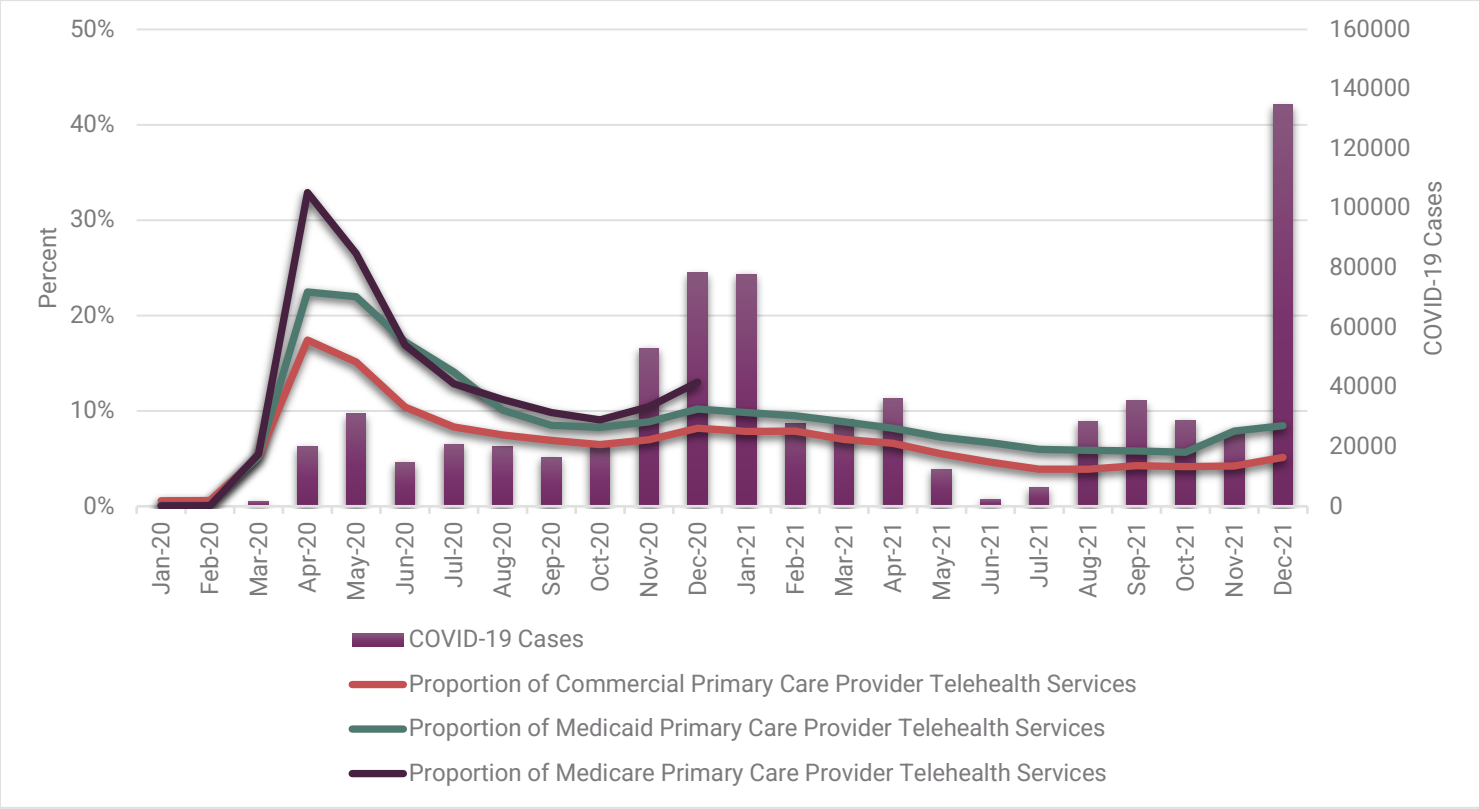


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of behavioral health care telehealth services per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Service type was identified through BETOS codes. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Behavioral services were defined by BETOS subgroup code EB.

Exhibits for the Trends in the Proportion of E&M telehealth services per month for commercial, Medicaid, and Medicare populations by provider type (primary/specialty care provider vs. behavioral health provider).

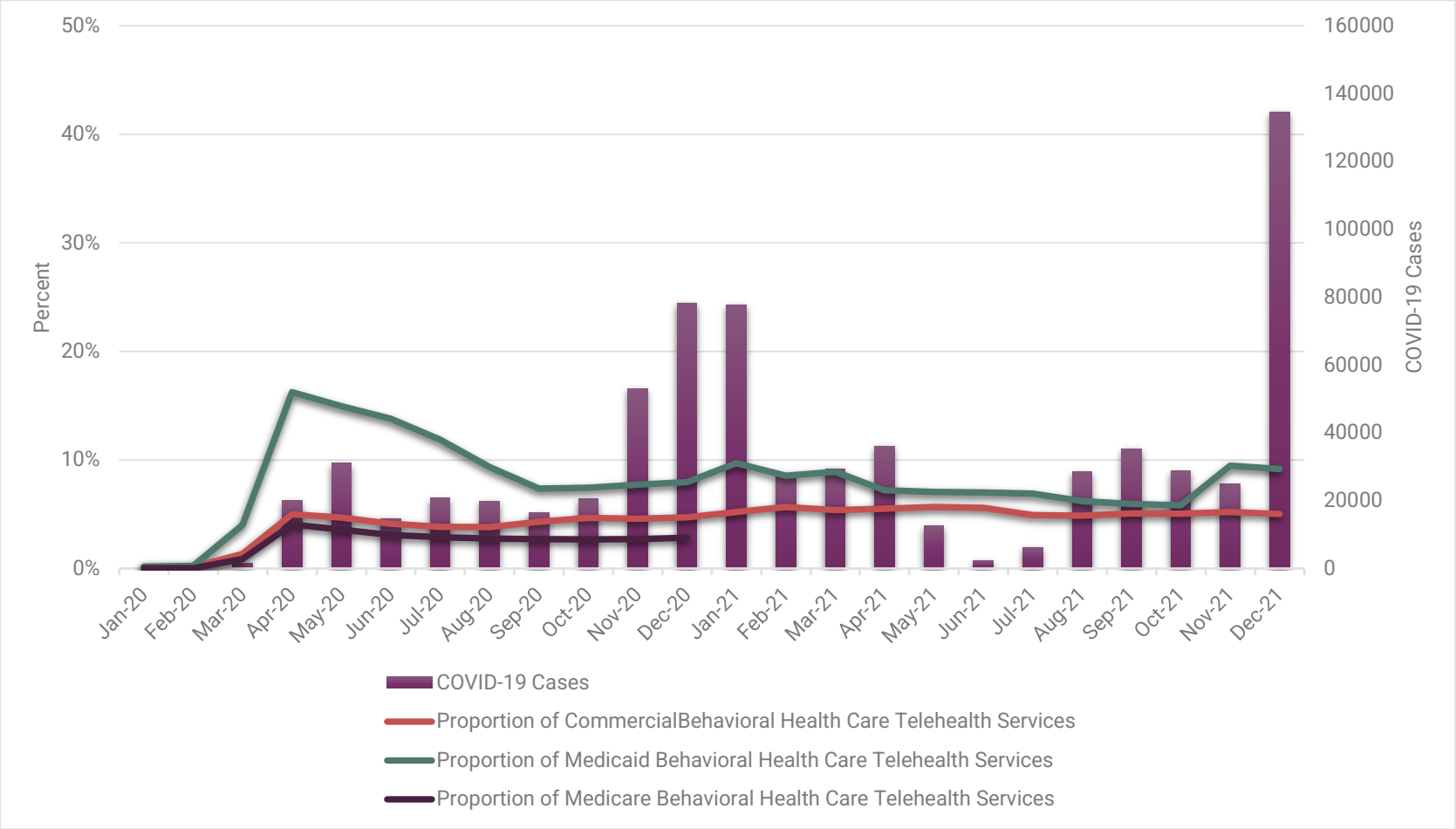
Few primary care and behavioral health care providers used telehealth prior to the PHE. A rapid uptake of the telehealth rate during the early months of the PHE with Medicaid behavioral health providers maintaining a higher level of telehealth use throughout the study period.

Proportion of Telehealth Services by Primary Care Providers per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, E&M services furnished by primary care and specialty care providers



Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of telehealth services by primary care providers per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Provider type was identified through specialty. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider types were identified using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and NUCC crosswalks.

Proportion of Telehealth Services by Behavioral Health Care Providers per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, services furnished by behavioral health care providers

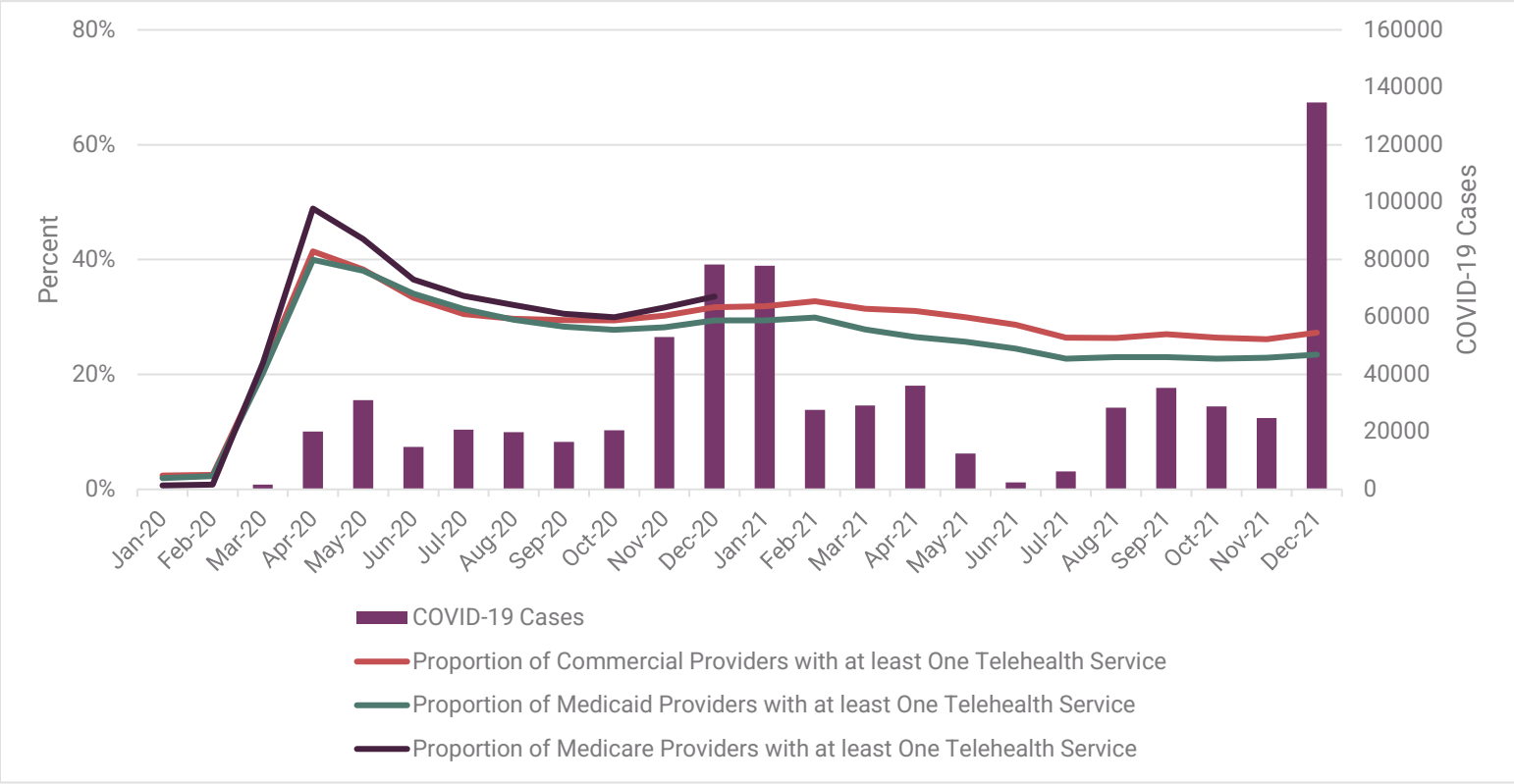


Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of telehealth services by behavioral health care providers per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. Provider type was identified through specialty. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Provider types were identified using provider specialty codes and taxonomy codes contained in claims and where not available, in the NPPES and NUCC crosswalks.

Exhibit for the trend in the proportion of providers with at least one E&M telehealth service servicing commercial, Medicaid, and Medicare populations.

Few providers used telehealth prior to the PHE, with about 40% of providers, across all three payor types, using telehealth to provide E&M services at the start of the PHE. Overall, patterns were similar between commercial and Medicaid providers, with less than 30% of providers providing E&M services by telehealth by the end of the study period.

Proportion of Providers With at Least One Telehealth Service per Month in Maryland 2020 to 2021 across Commercial, Medicaid, and Medicare Claims, all providers with at least one E&M service



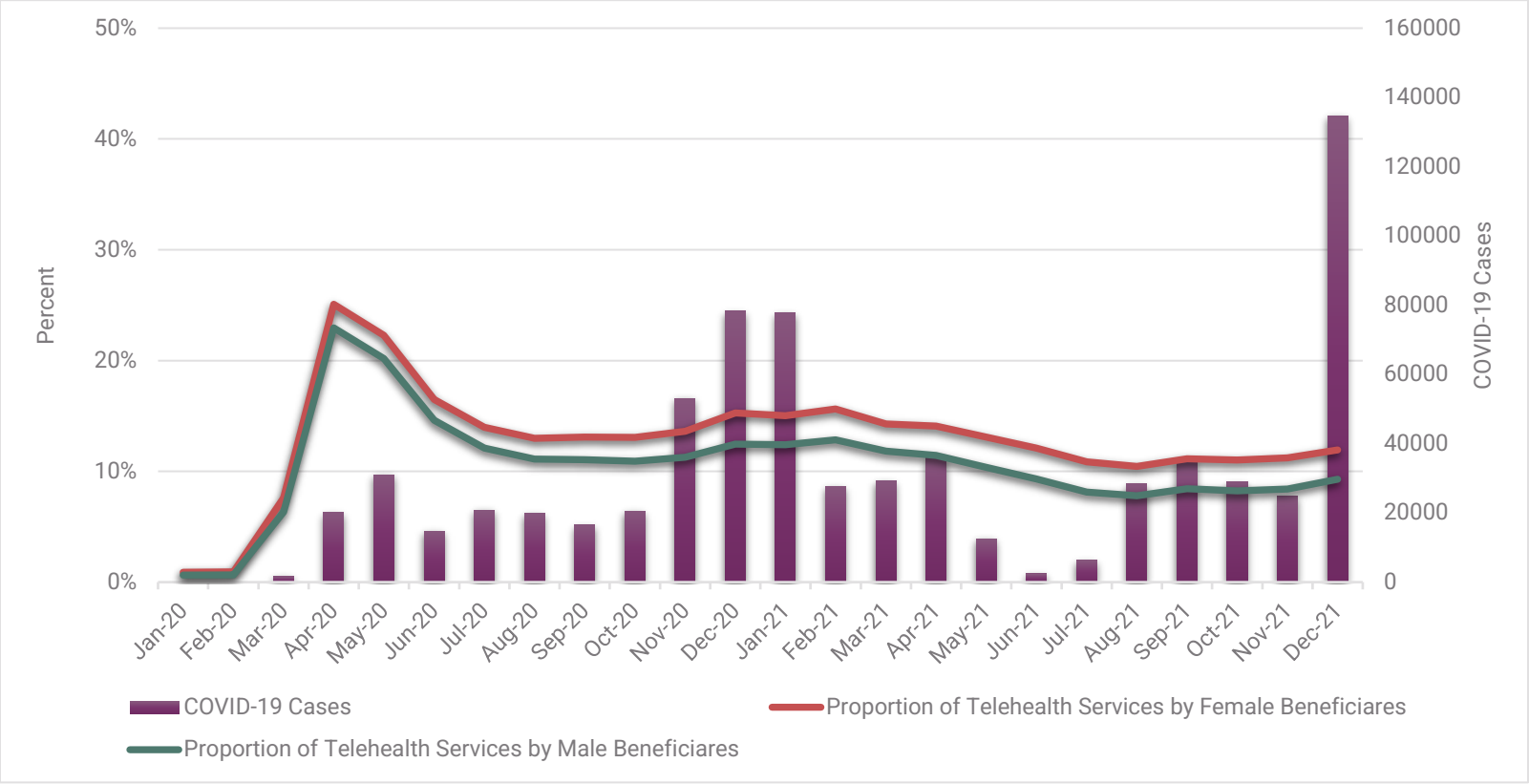
Notes: Maryland commercial all-payer database data from 2020 to 2021, Maryland Medicaid claims data from 2020 to 2021, and Maryland Medicare claims data from 2020 were utilized to identify the proportion of providers with at least one telehealth service per month. Data for 2021 Maryland Medicare claims was unavailable at the time of analysis. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021.

Exhibits for the analyses of sub-populations presented for commercial, Medicaid, and Medicare populations separately, for a total of three graphs for each sub-population.

Trends were similar in payor specific analyses as in the overall analyses presented in the main report. Overall, utilization of E&M services by telehealth varied by population subgroups. Higher utilization was observed among younger individuals, those residing in urban areas, and female patients.

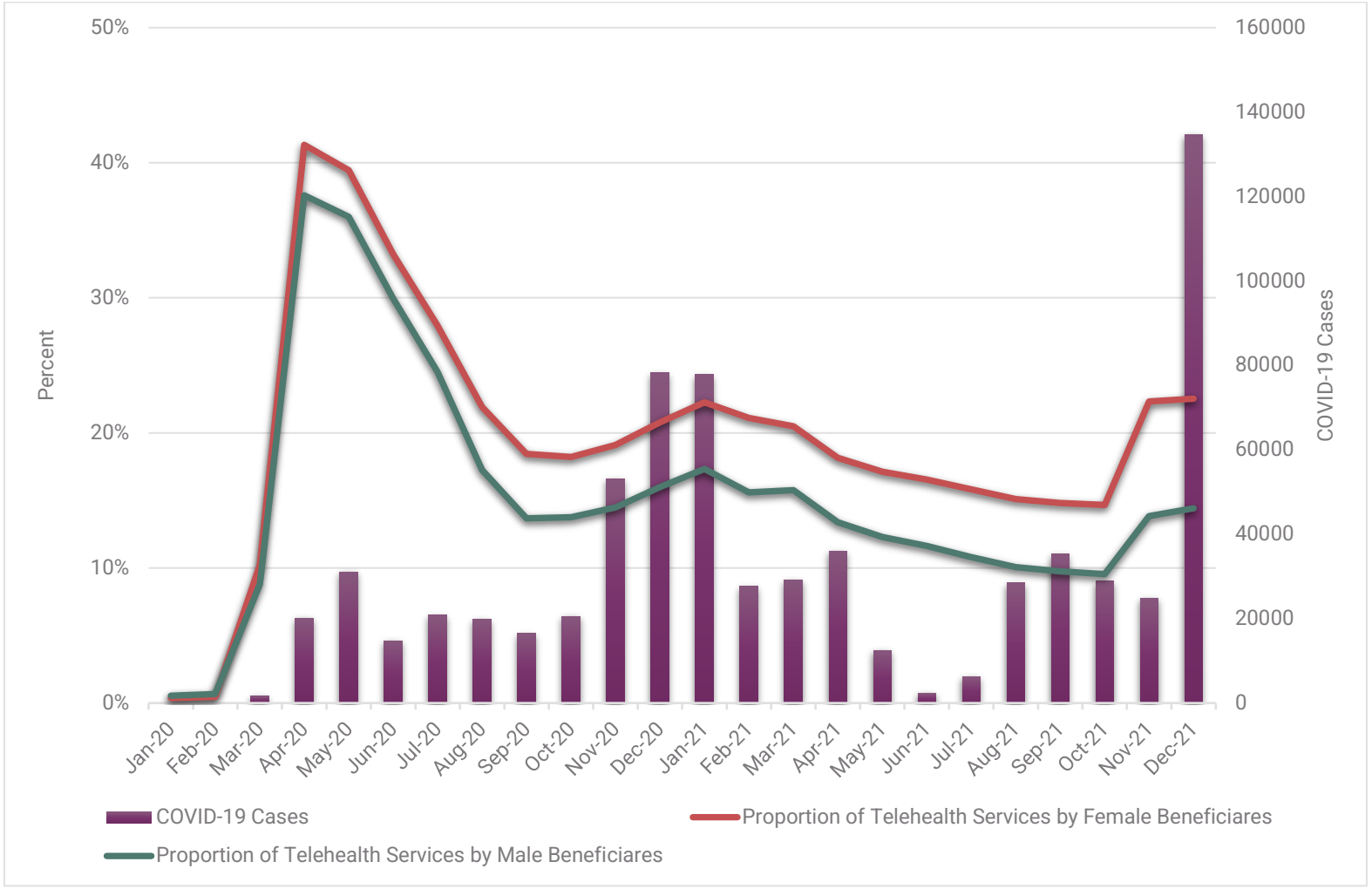
Gender

Proportion of Telehealth Services by Gender per Month in Maryland 2020 to 2021 Commercial Claims



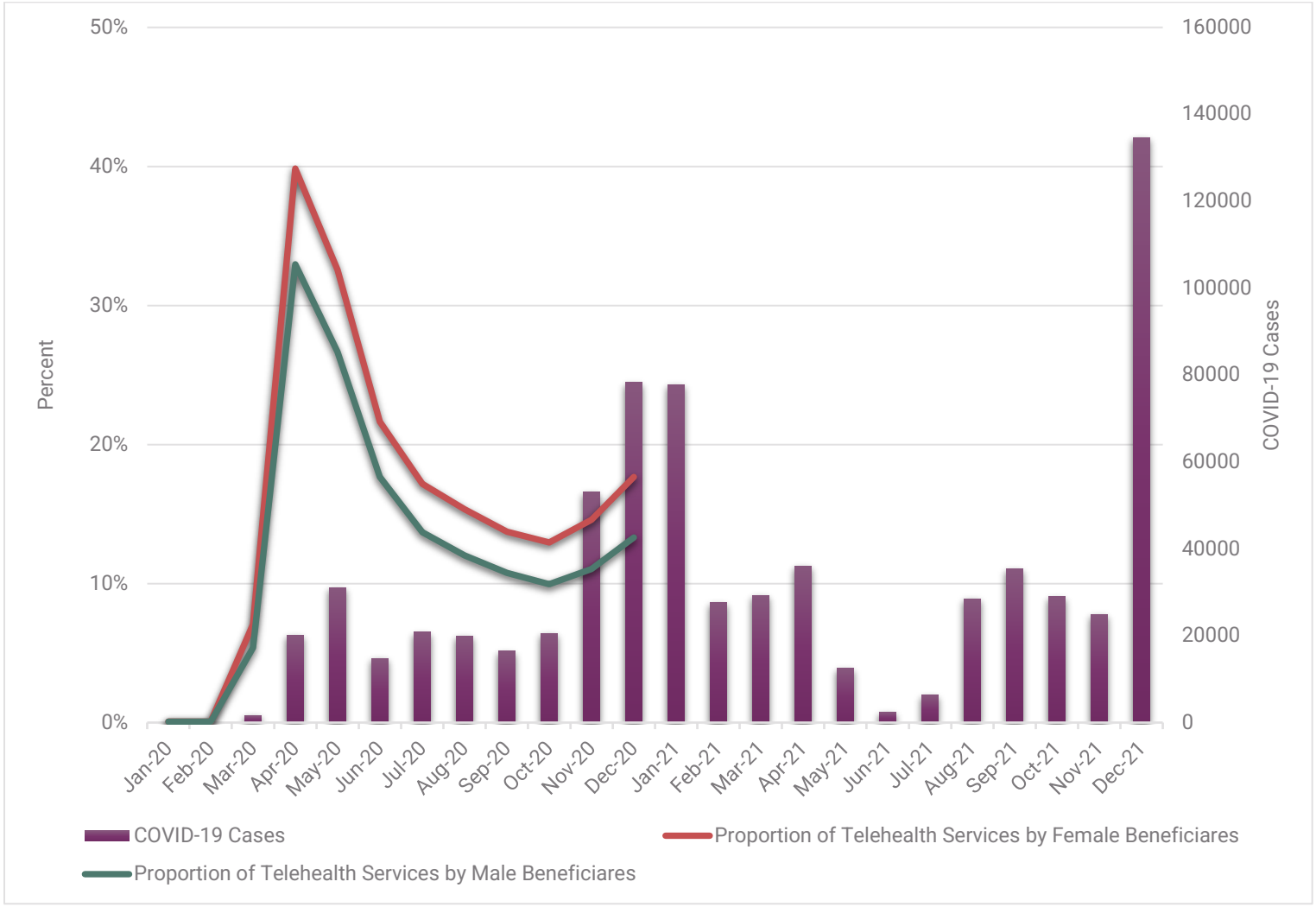
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the proportion of telehealth services by gender per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant across the observed period. Patterns were similar within service type and provider type subgroups

Proportion of Telehealth Services by Gender per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the proportion of telehealth services by gender per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant across the observed period. Patterns were similar within service type and provider type subgroups.

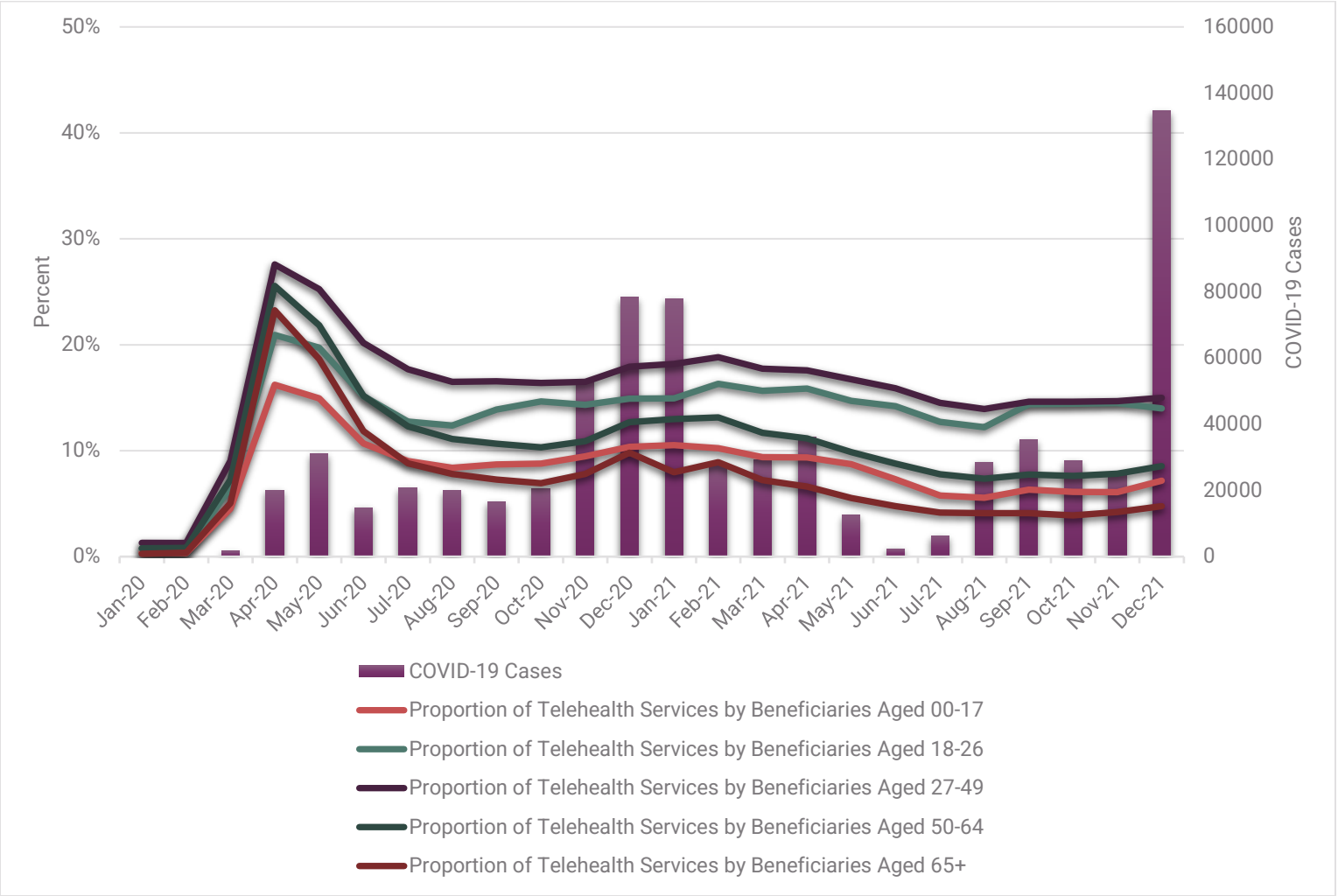
Proportion of Telehealth Services by Gender per Month in Maryland 2020 Medicare Claims



Notes: Maryland Medicare claims data from 2020 was utilized to identify the proportion of telehealth services by gender per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Patterns were similar within service type and provider type subgroups.

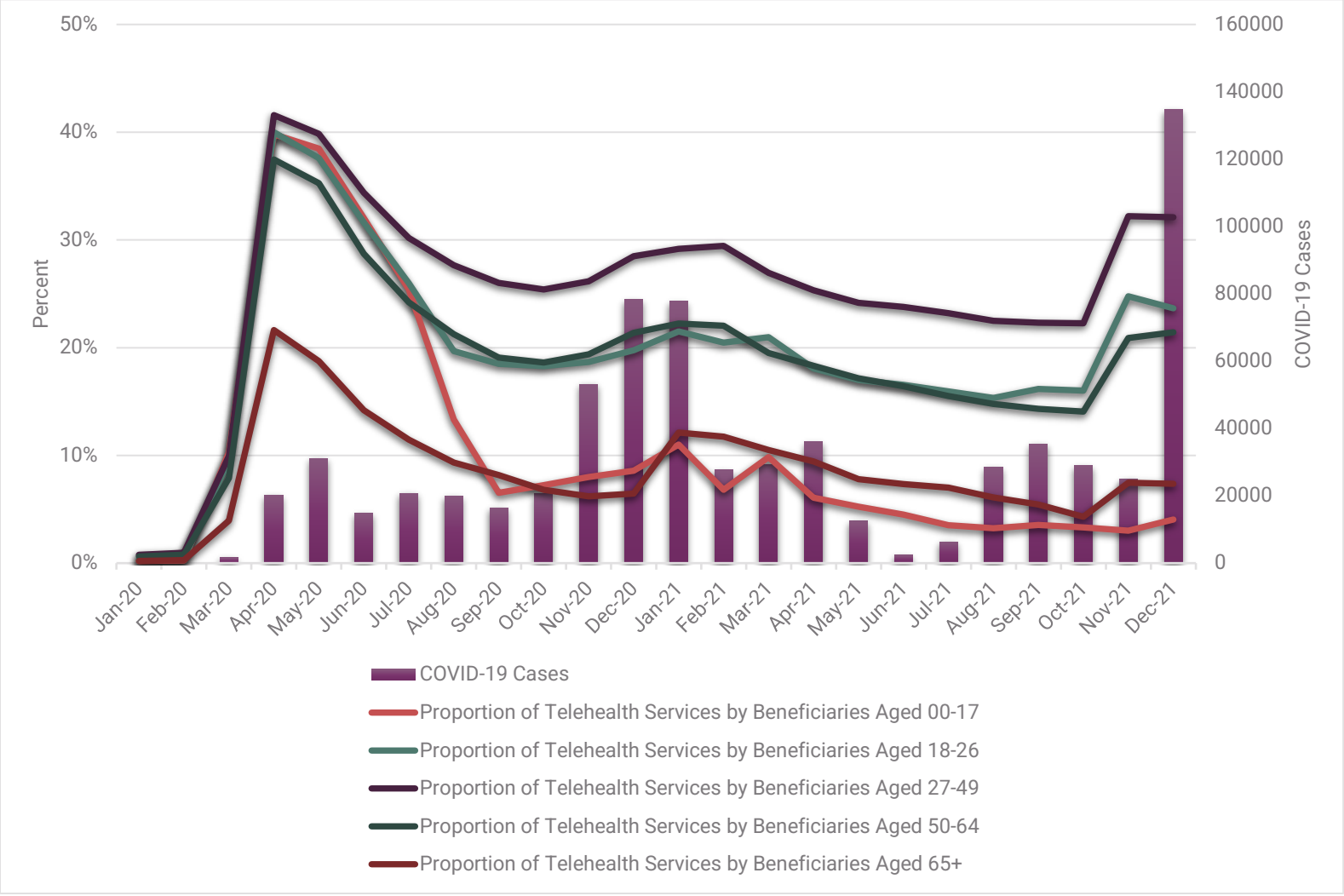
Age

Proportion of Telehealth Services by Age Group per Month in Maryland 2020 to 2021 Commercial Claims



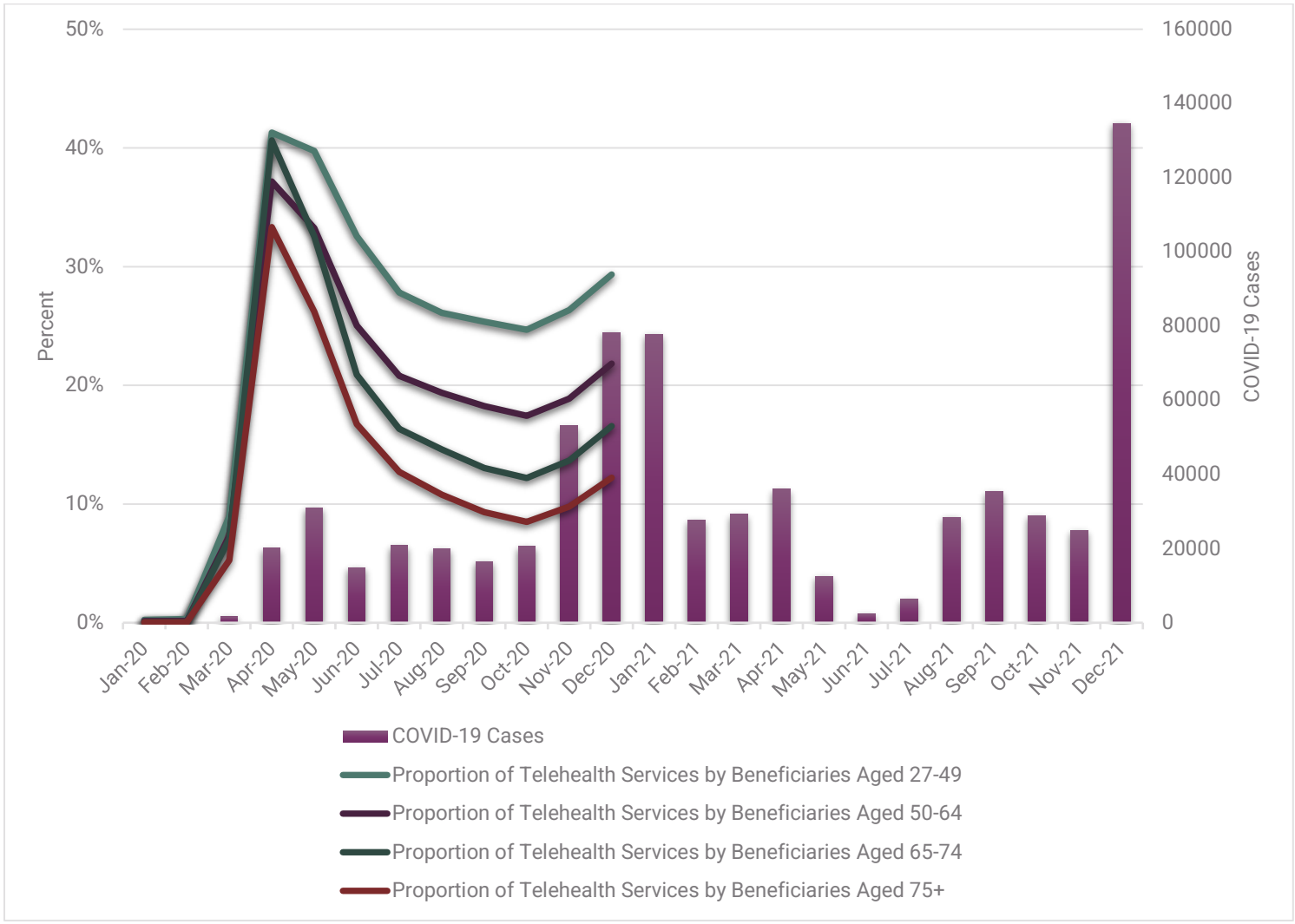
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the proportion of telehealth services by age per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant across the observed period. Patterns were similar within service type and provider type subgroups.

Proportion of Telehealth Services by Age Group per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the proportion of telehealth services by age per month. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant across the observed period. Proportion of telehealth services by beneficiaries aged 65+ was substantially higher in behavioral health care services than in somatic care services, and similarly in services furnished by behavioral health care providers than in services furnished by primary care and specialty care providers.

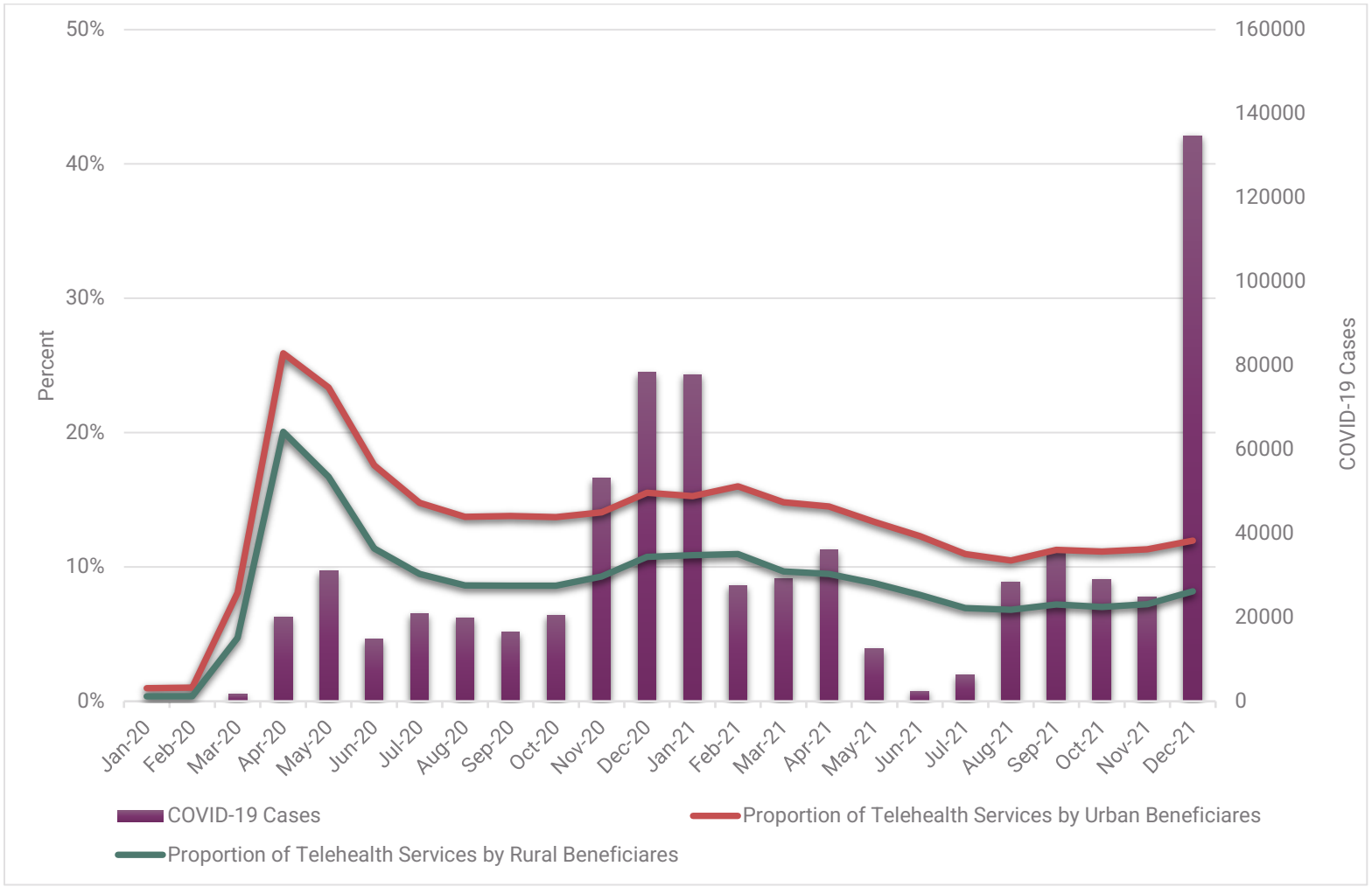
Proportion of Telehealth Services by Age Group per Month in Maryland 2020 Medicare Claims



Notes: Maryland Medicare claims data from 2020 was utilized to identify the proportion of telehealth services by age per month. Data for beneficiaries aged 00 through 26 was excluded due to low sample size. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Rates of telehealth utilization among beneficiaries aged 65-74 were comparable to that among younger beneficiaries when limited to services furnished by a behavioral health care provider.

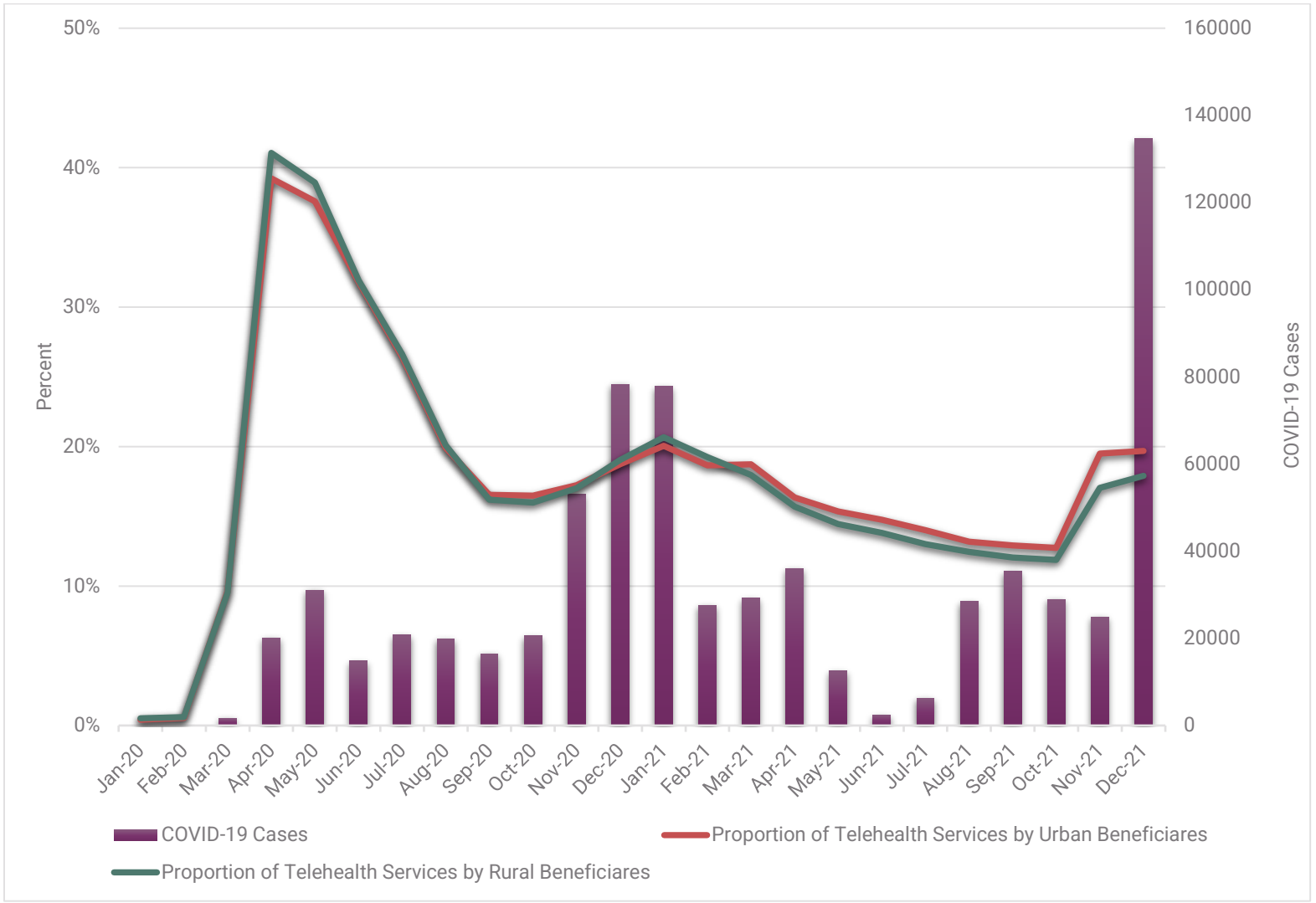
Urban/Rural

Proportion of Telehealth Services by Urban or Rural Status per Month in Maryland 2020 to 2021 Commercial Claims



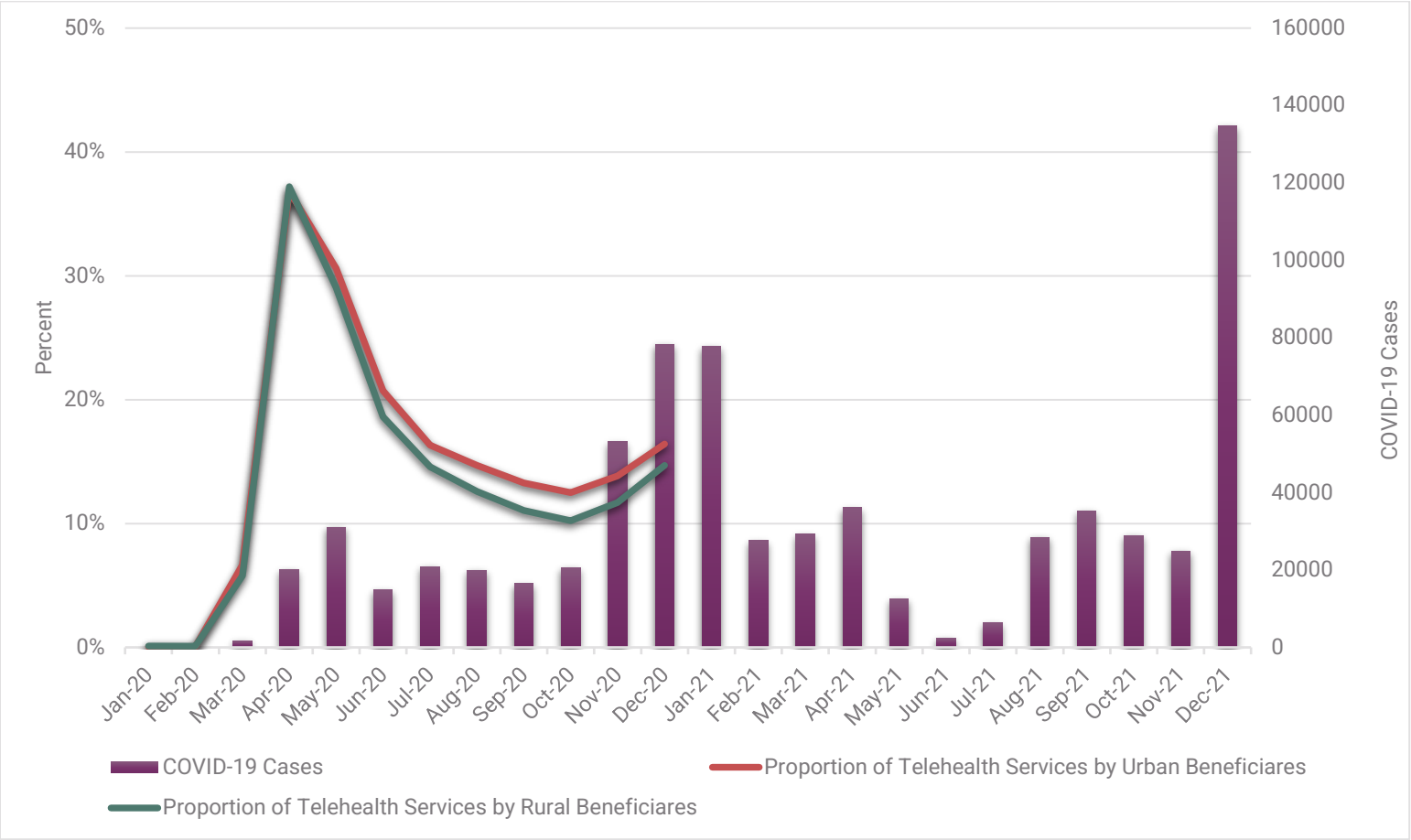
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the proportion of telehealth services by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant across the observed period. Patterns were similar within service type and provider type subgroups.

Proportion of Telehealth Services by Urban or Rural Status per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the proportion of telehealth services by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Though rural-urban differences were not meaningful, they were significant during most months across the observation period. Patterns were similar within service type and provider type subgroups.

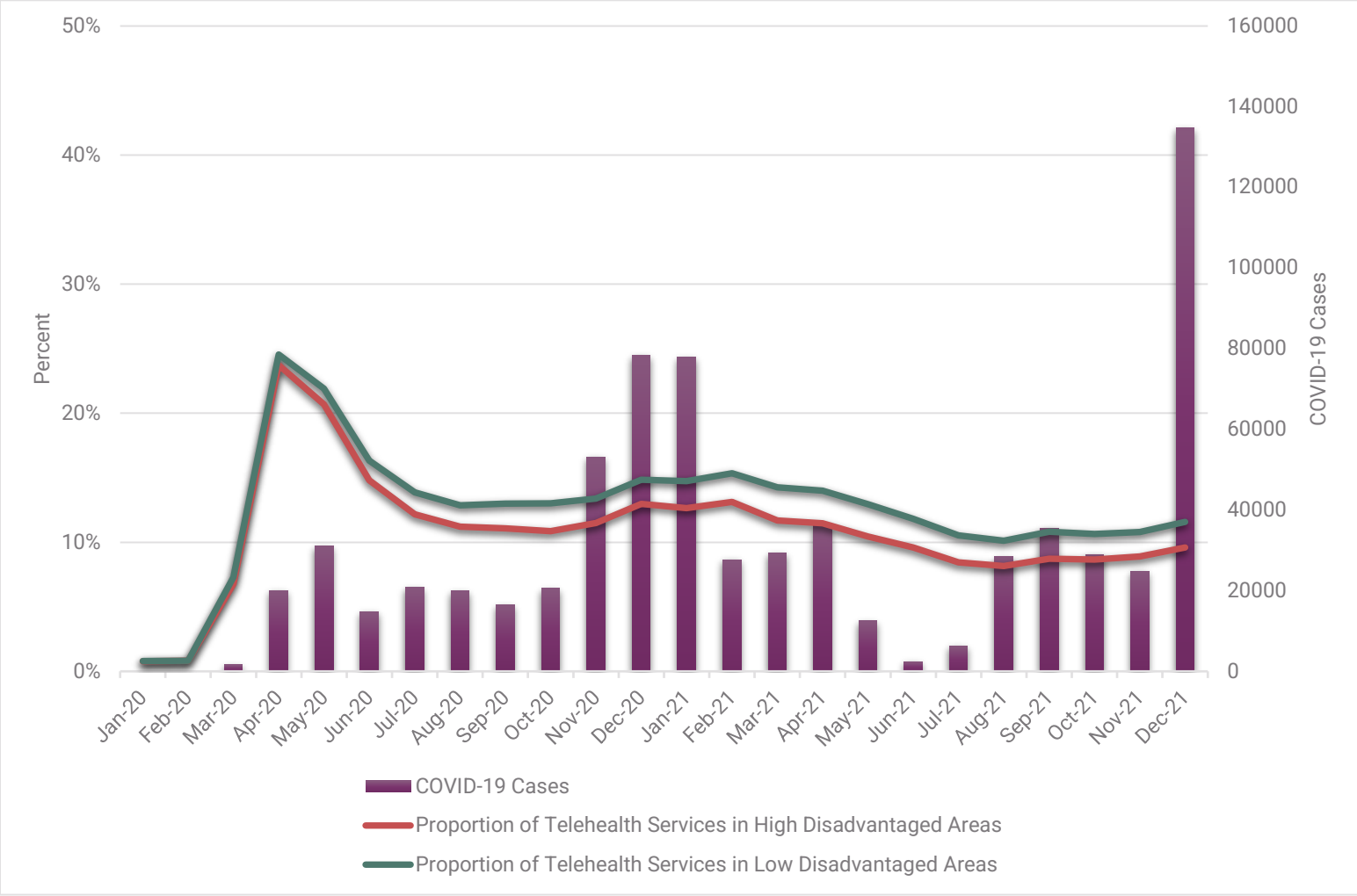
Proportion of Telehealth Services by Urban or Rural Status per Month in Maryland 2020 Medicare Claims



Notes: Maryland Medicare claims data from 2020 was utilized to identify the proportion of telehealth services by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Patterns were similar within service type and provider type subgroups.

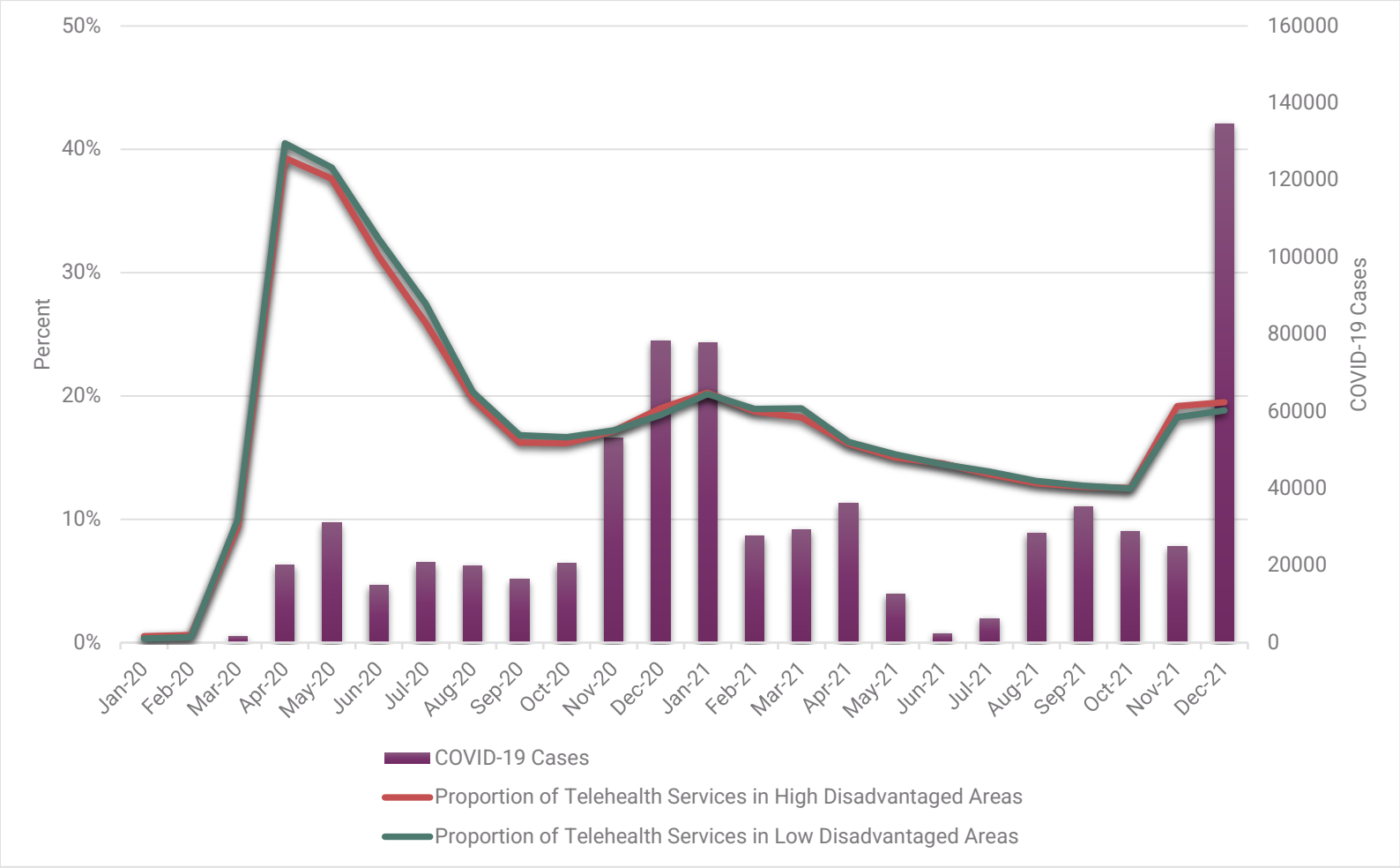
ADI

Proportion of Telehealth Services by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 to 2021 Commercial Claims



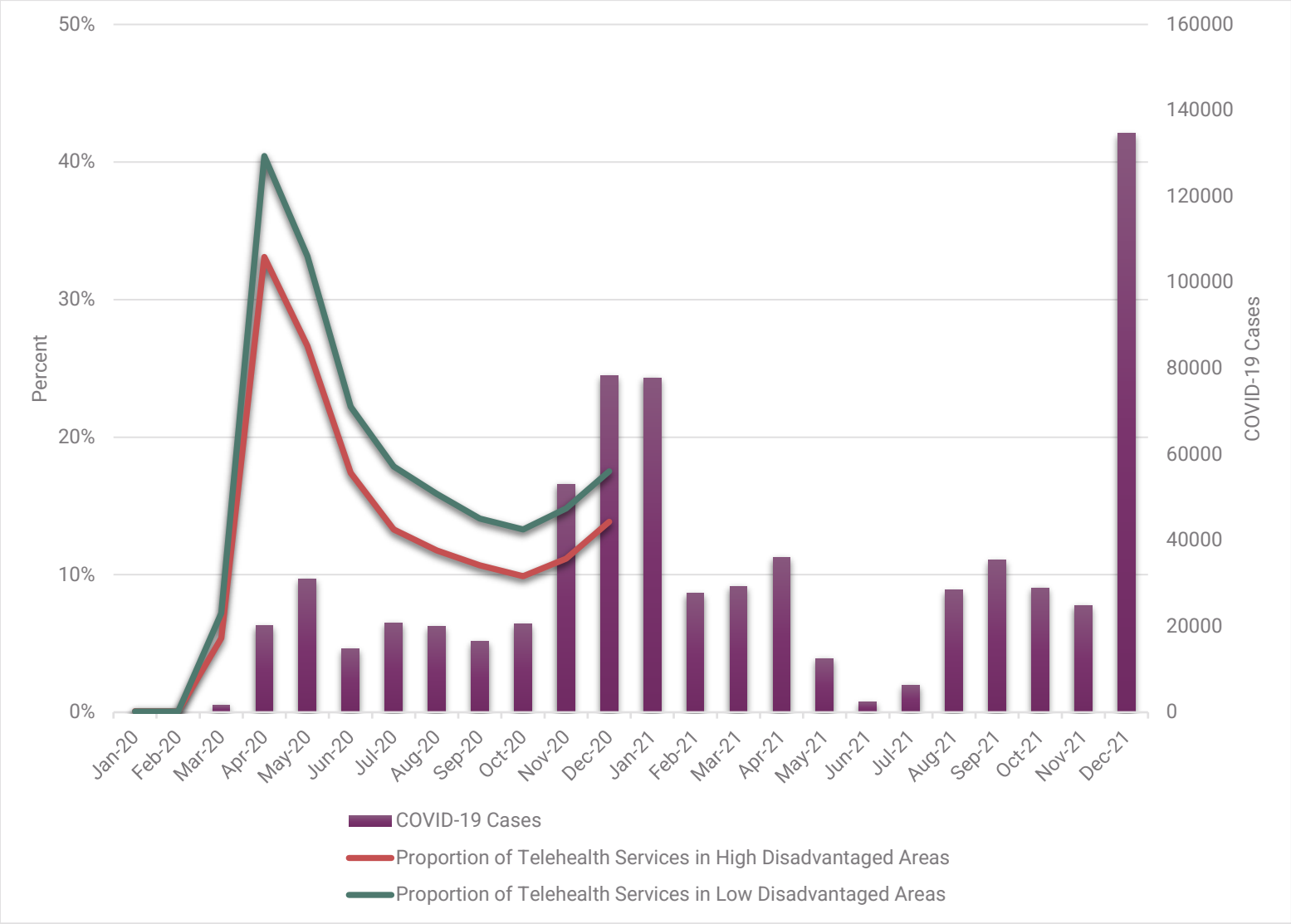
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the proportion of telehealth services per month. High- vs. low-disadvantage were determined at the zip-code level using Area Deprivation Index 2019 data. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Differences were significant after March 2020. Patterns were similar within service type and provider type subgroups.

Proportion of Telehealth Services by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the proportion of telehealth services per month. Disadvantaged areas were determined at the zip-code level using Area Deprivation Index 2019 data. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Though high- vs. low- ADI differences were not meaningful, they were significant during most months across the observation period. Patterns were similar within service type and provider type subgroups.

Proportion of Telehealth Services by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 Medicare Claims

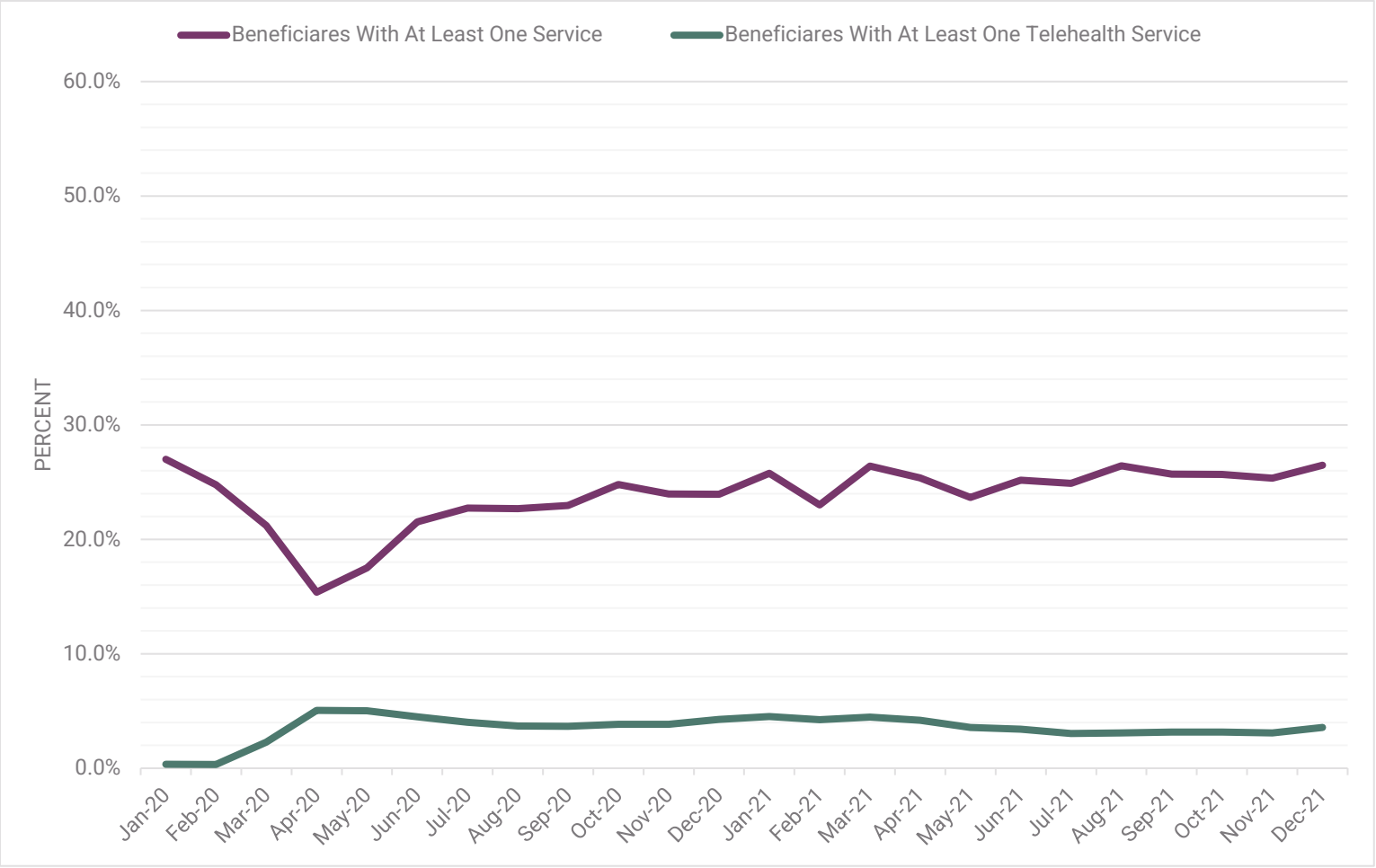


Notes: Maryland Medicare claims data from 2020 was utilized to identify the proportion of telehealth services per month. Disadvantaged areas were determined at the zip-code level using Area Deprivation Index 2019 data. The Johns Hopkins University Center for Systems Science and Engineering COVID-19 Dataset was utilized to identify the monthly number of COVID-19 cases in Maryland from 2020 to 2021. Patterns were similar within service type and provider type subgroups.

Exhibits for beneficiaries with at least one service per month

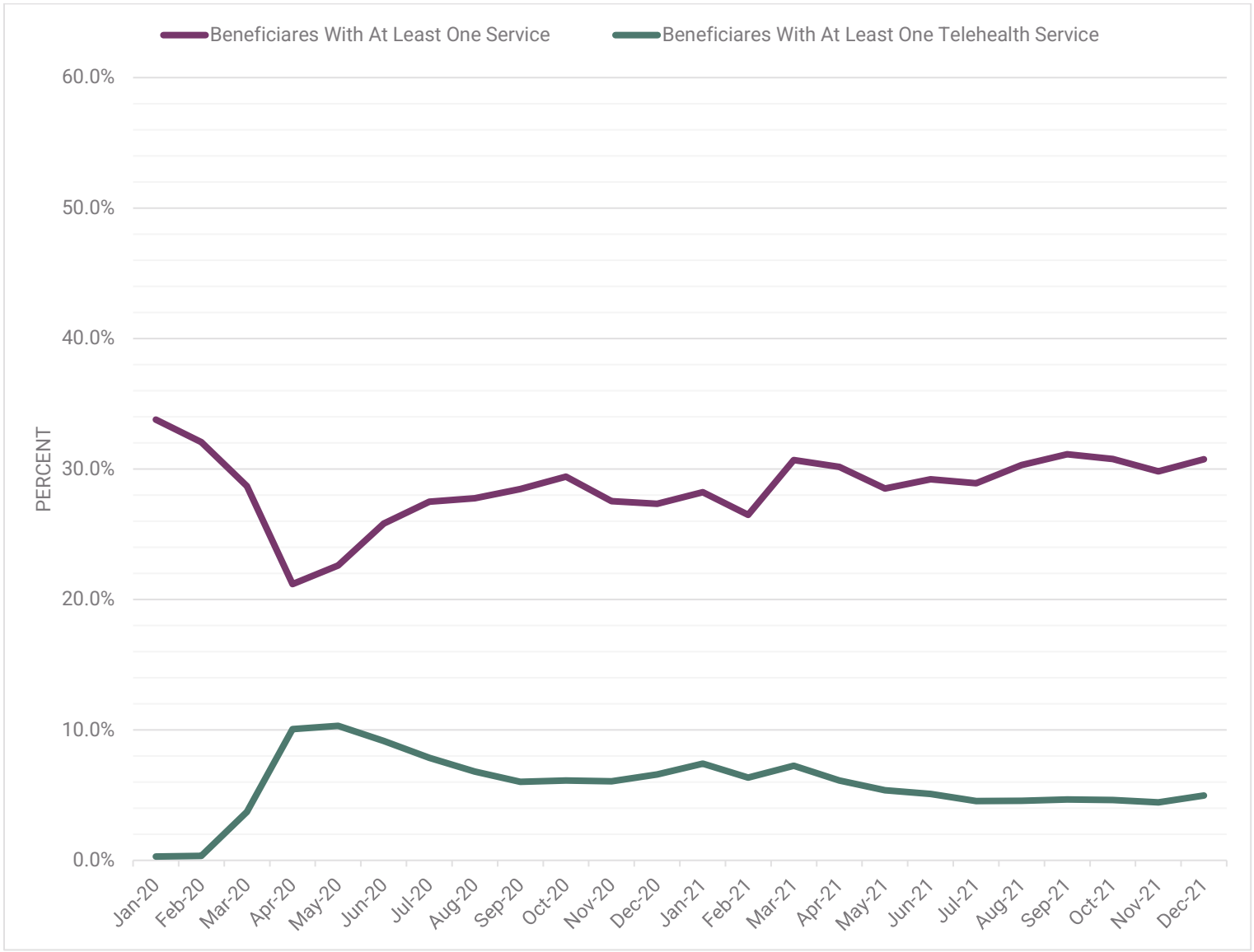
Throughout the study period, only a portion of beneficiaries utilizing services had at least one telehealth service. The pattern was similar across all payors and sub-population analyses.

Percent of Beneficiaries With at Least One Service per Month in Maryland 2020 to 2021 Commercial Claims



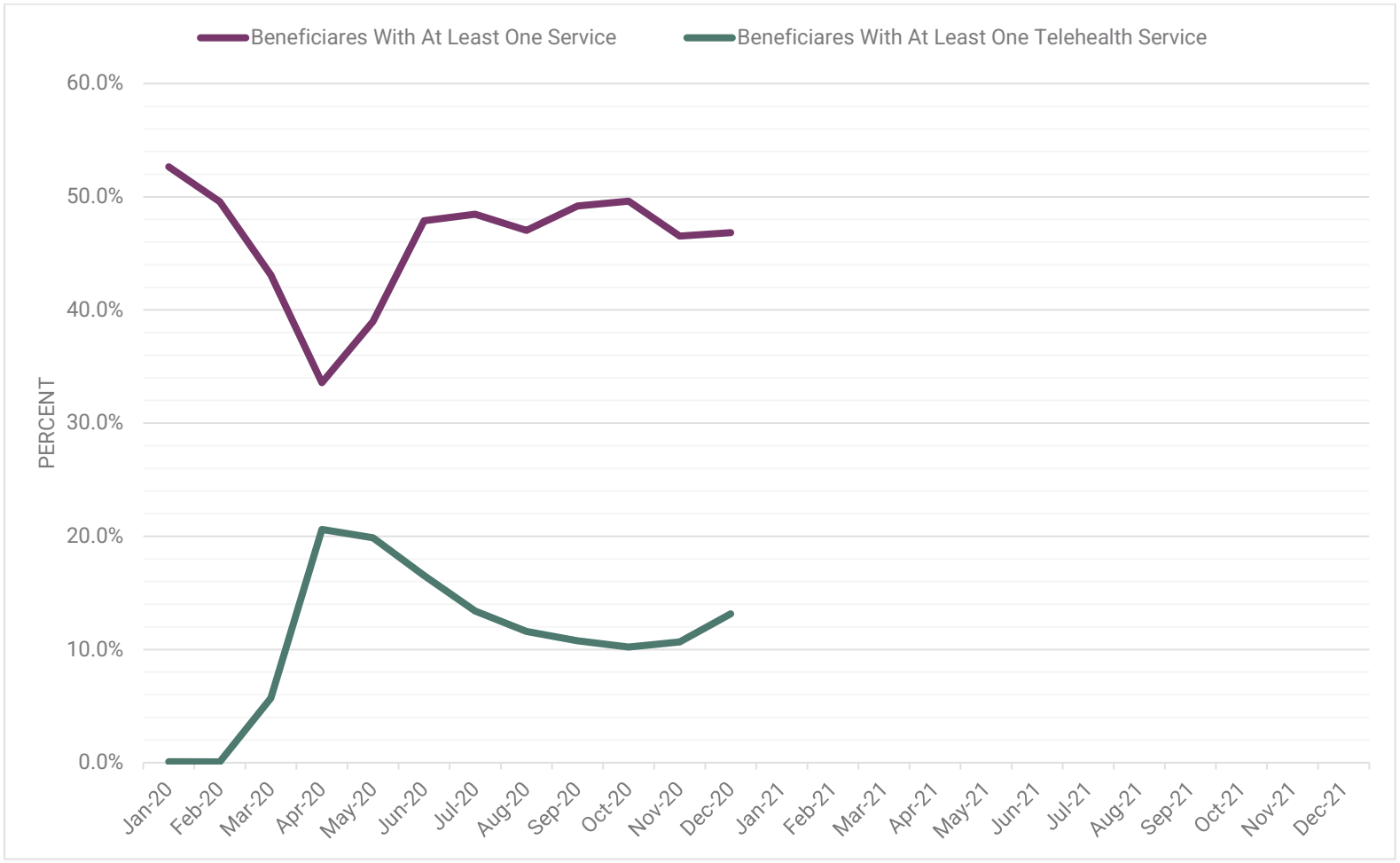
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month.

Percent of Beneficiaries With at Least One Service per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month.

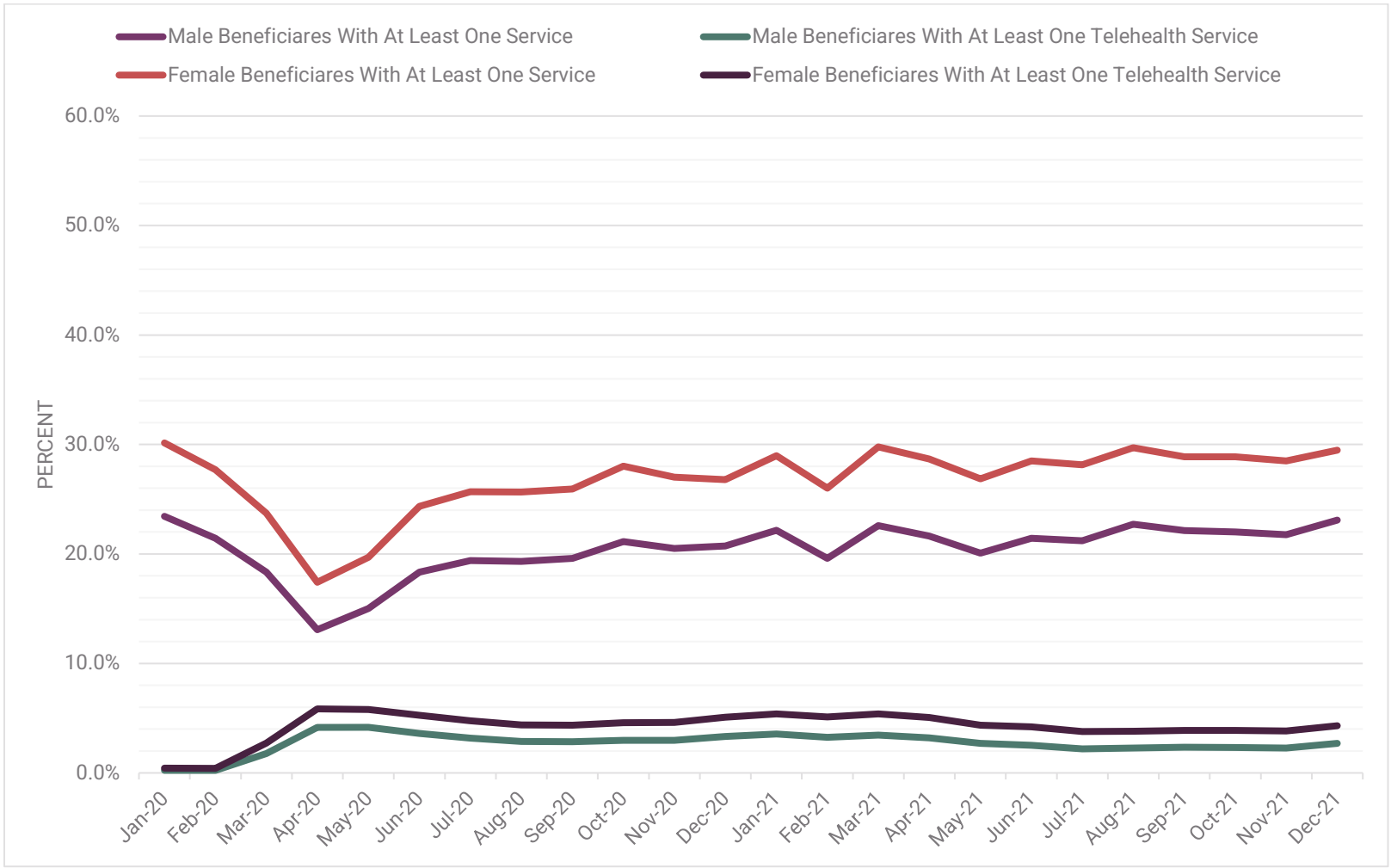
Percent of Beneficiaries With at Least One Service per Month in Maryland 2020 Medicare Claims



Notes: Maryland Medicare claims data from 2020 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month.

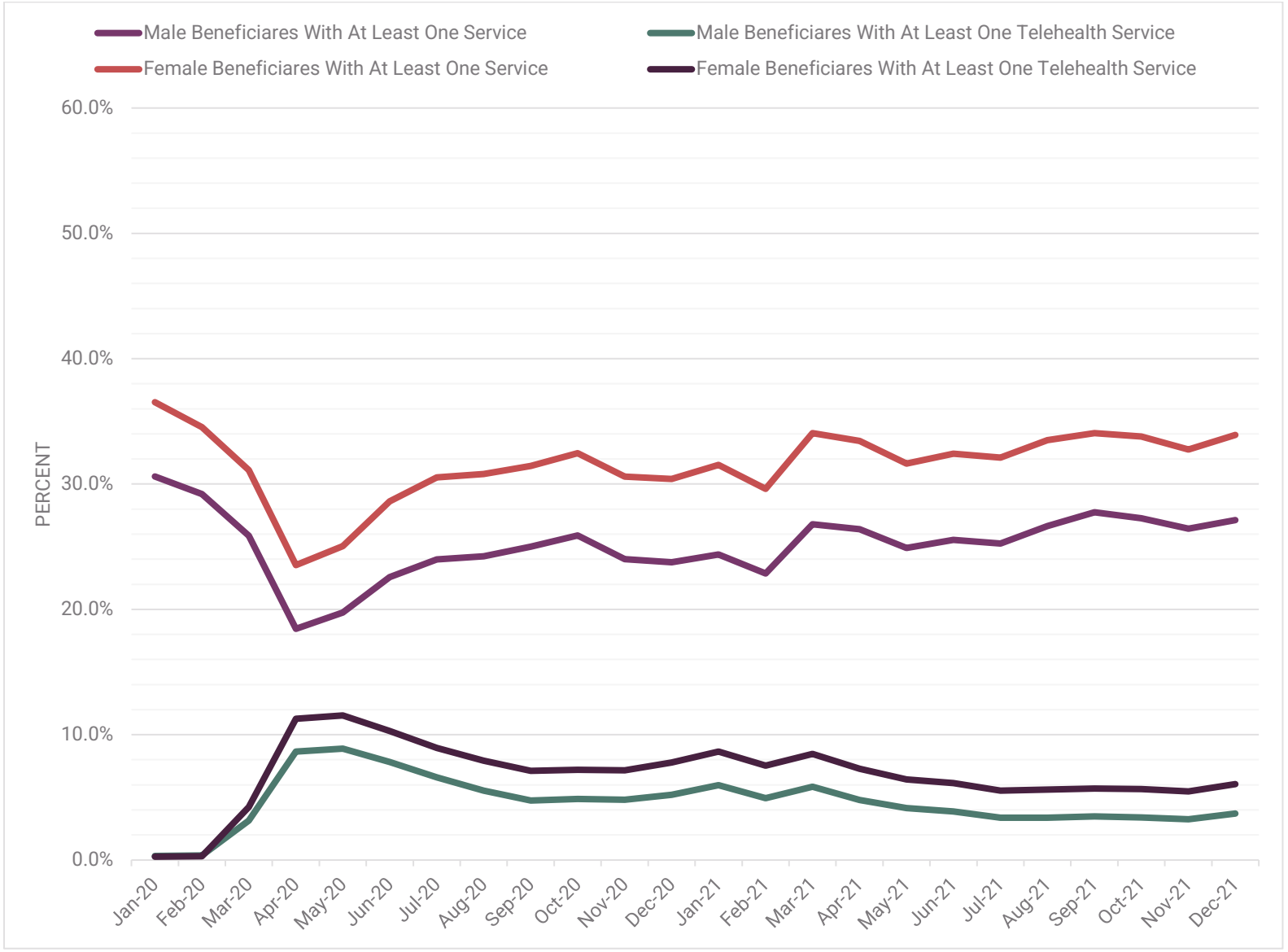
Gender

Percent of Beneficiaries With at Least One Service by Gender per Month in Maryland 2020 to 2021 Commercial Claims



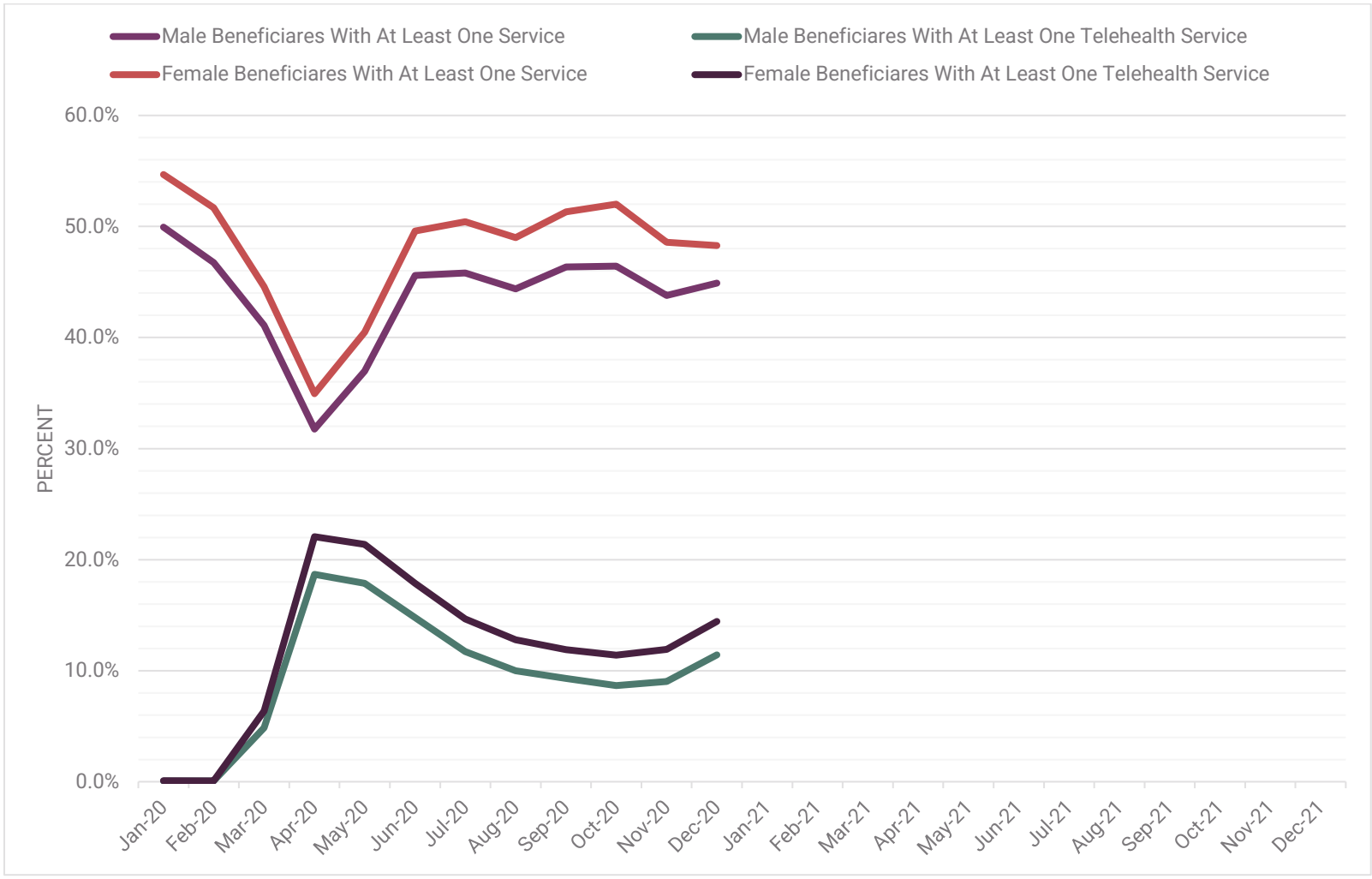
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by gender per month.

Percent of Beneficiaries With at Least One Service by Gender per Month in Maryland 2020 to 2021 Medicaid Claims



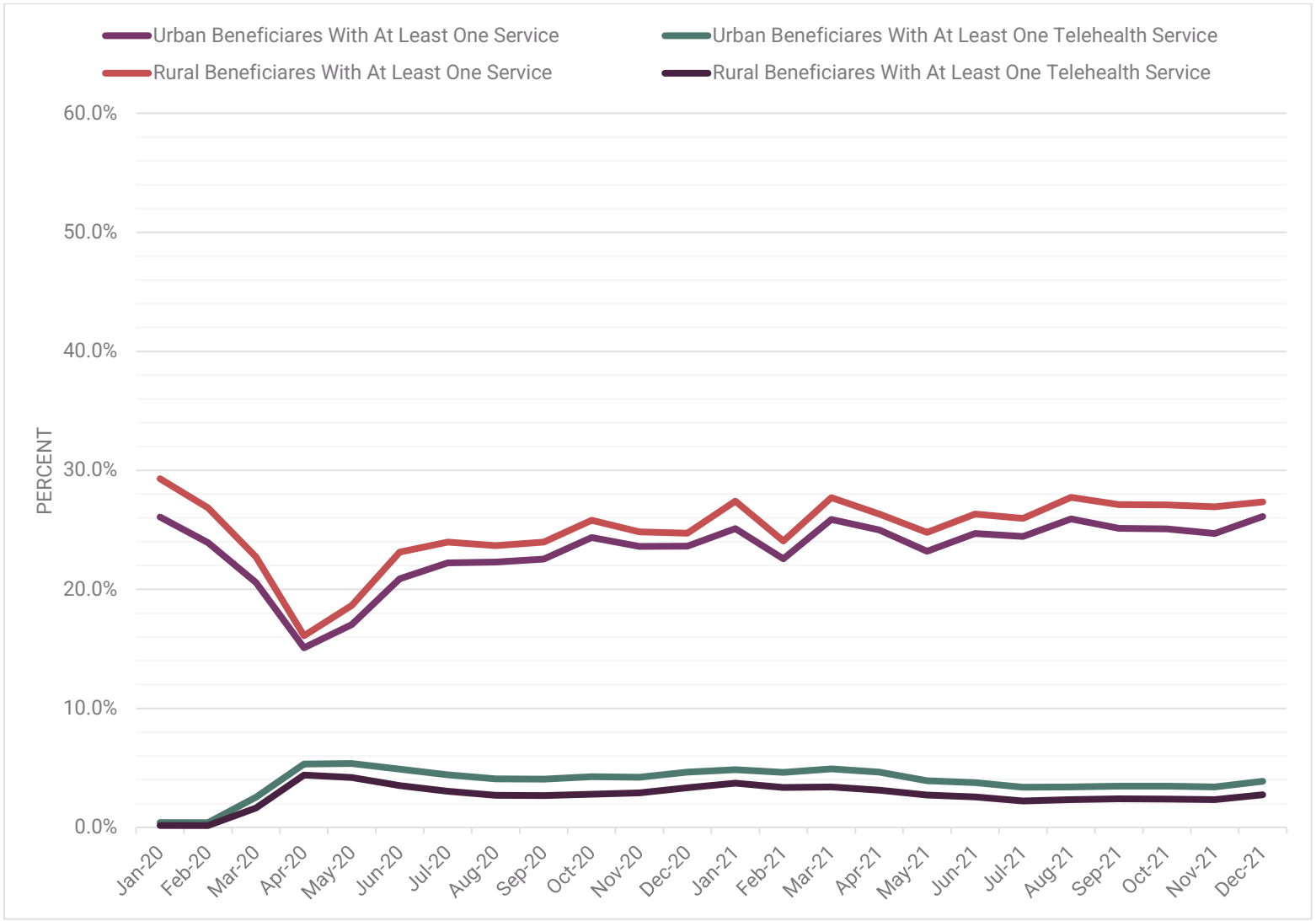
Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by gender per month.

Percent of Beneficiaries With at Least One Service by Gender per Month in Maryland 2020 Medicare Claims



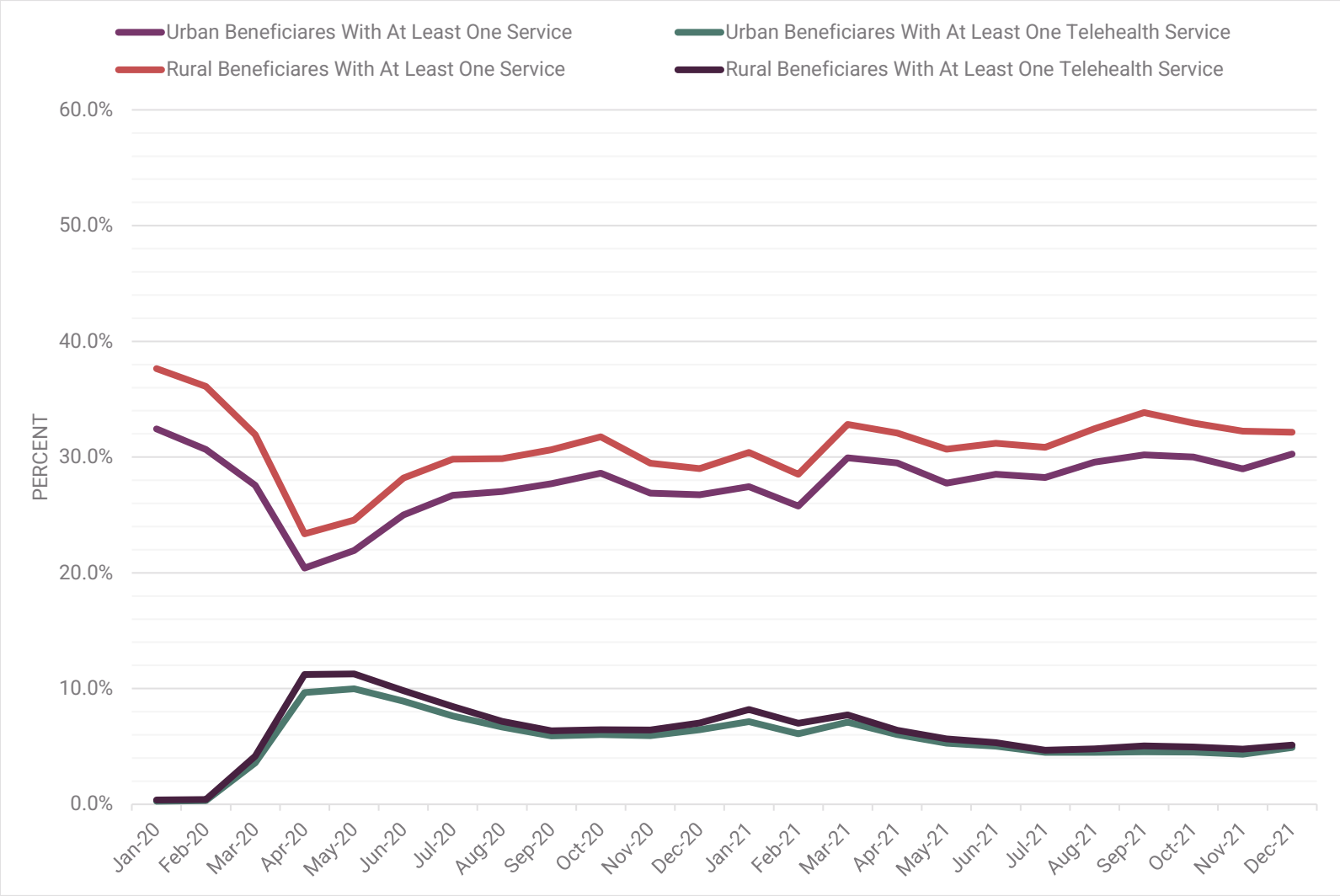
Notes: Maryland Medicare claims data from 2020 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by gender per month.

Percent of Beneficiaries With at Least One Service by Urban or Rural Status per Month in Maryland 2020 to 2021 Commercial Claims



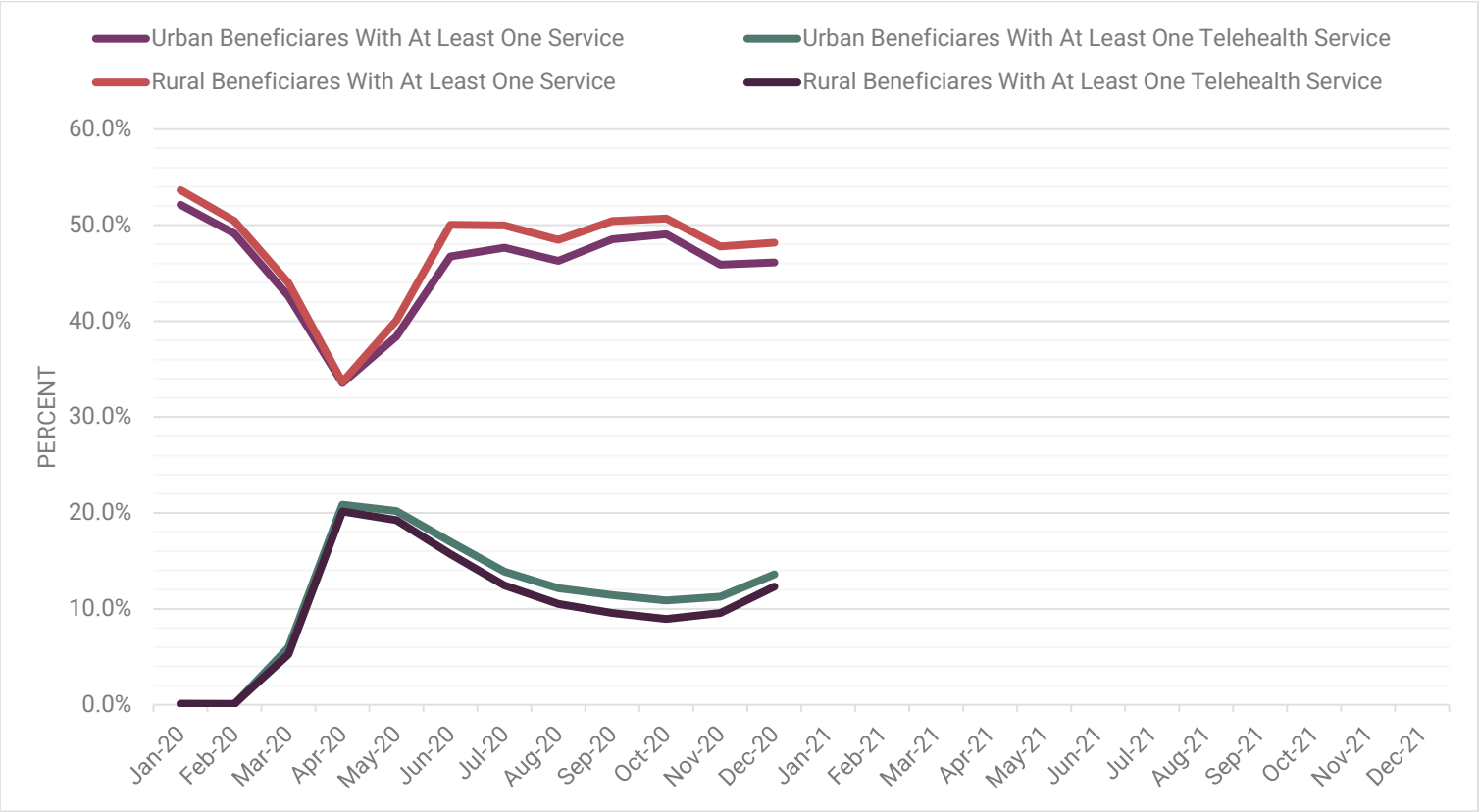
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council.

Percent of Beneficiaries With at Least One Service by Urban or Rural Status per Month in Maryland 2020 to 2021 Medicaid Claims



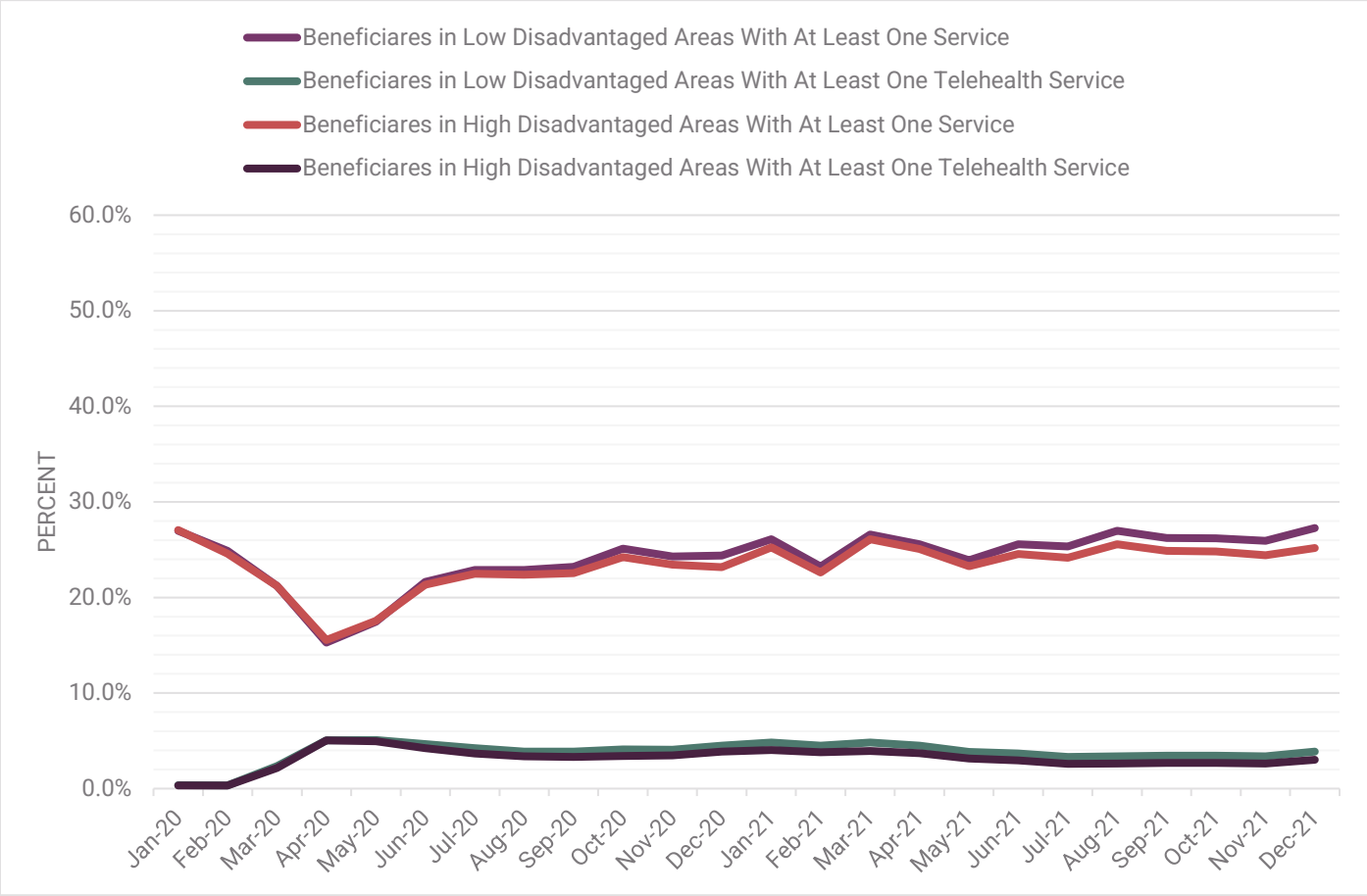
Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council.

Percent of Beneficiaries With at Least One Service by Urban or Rural Status per Month in Maryland 2020 Medicare Claims



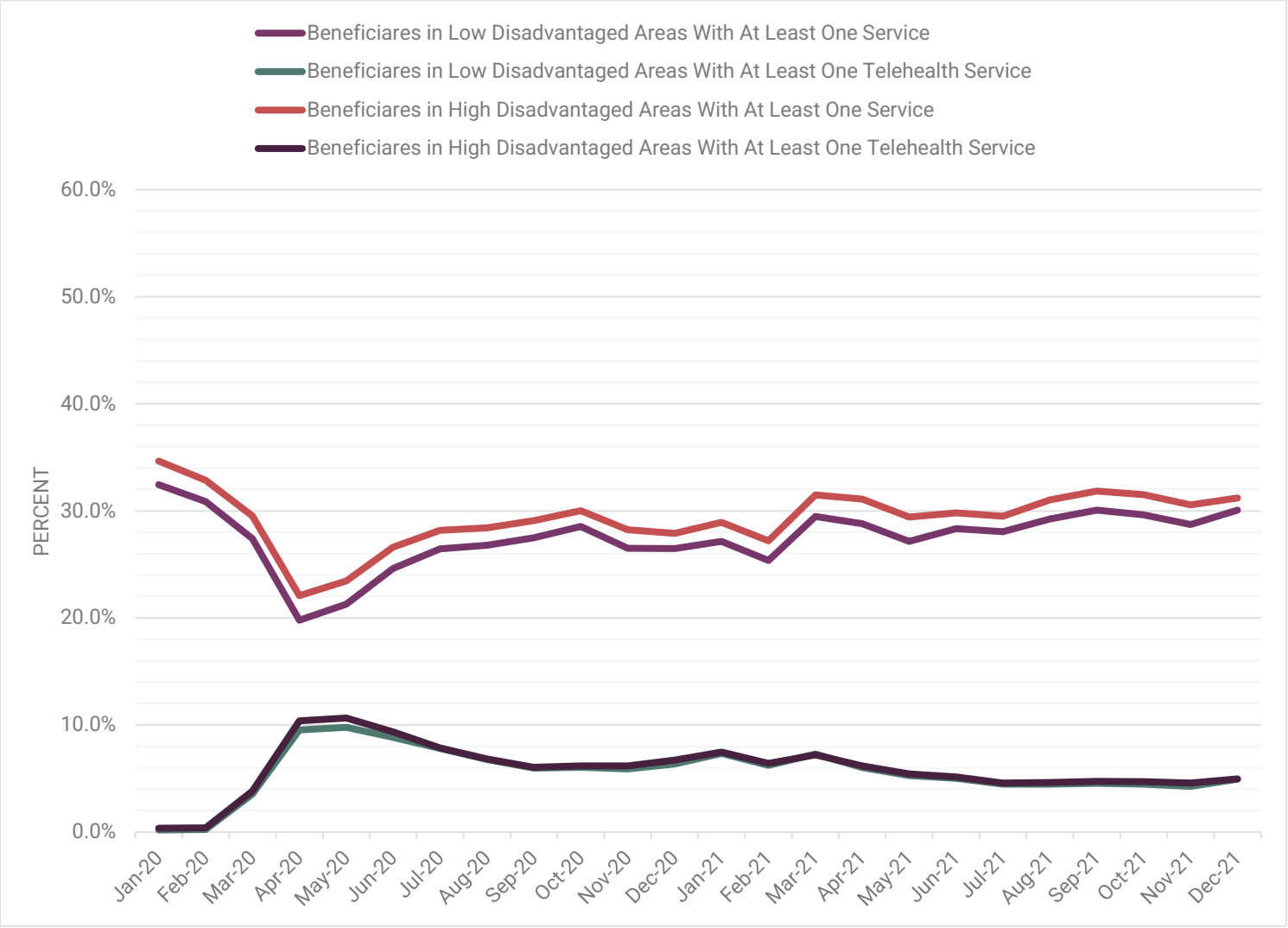
Notes: Maryland Medicare claims data from 2020 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service by urban and or status per month. Urban and rural status was determined at the county level and followed the classifications set by the Rural Maryland Council.

Percent of Beneficiaries With at Least One Service by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 to 2021 Commercial Claims



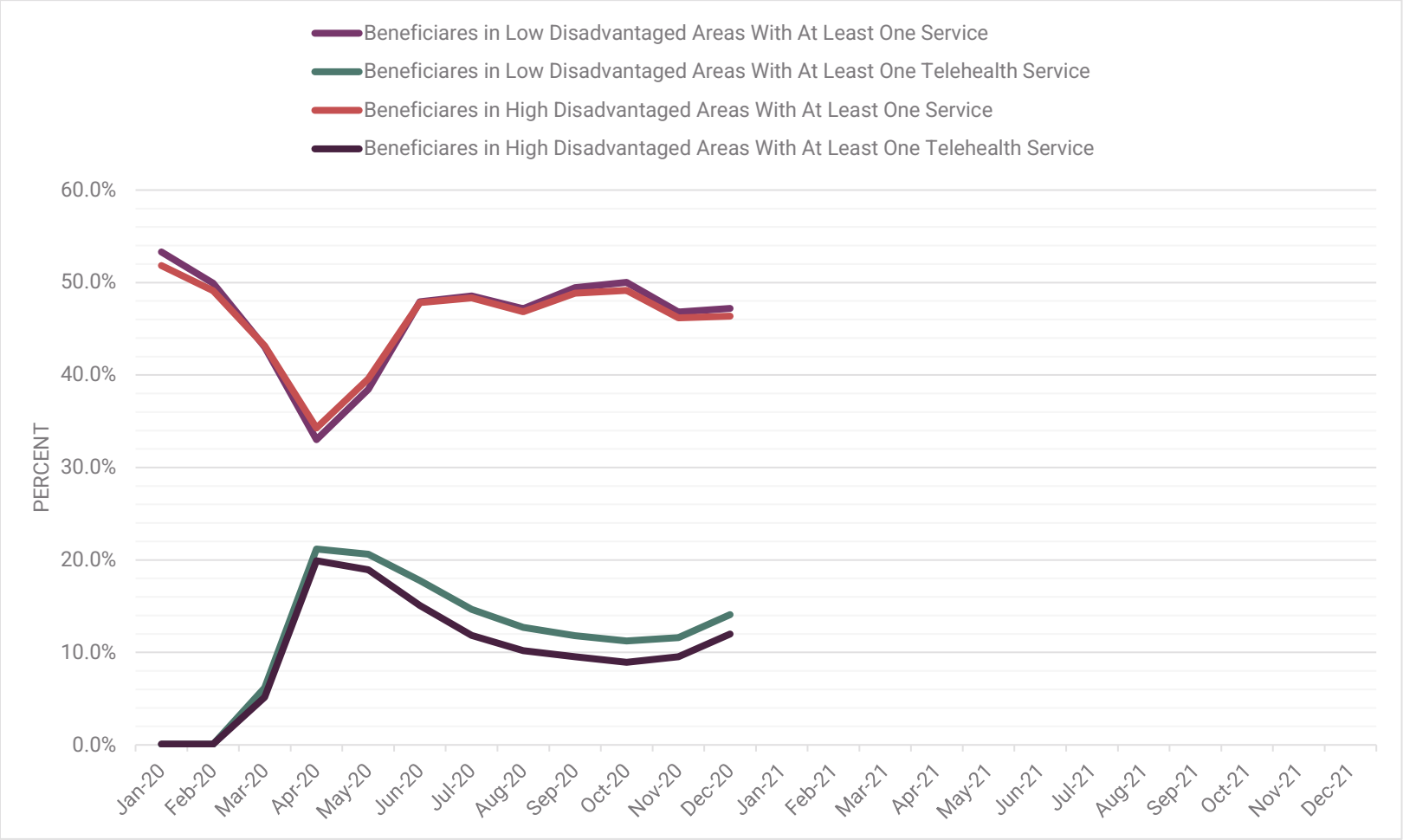
Notes: Maryland commercial all-payer database data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month. Disadvantaged areas were determined at the zip-code level using Area Deprivation Index 2019 data.

Percent of Beneficiaries With at Least One Service by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 to 2021 Medicaid Claims



Notes: Maryland Medicaid claims data from 2020 to 2021 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month. Disadvantaged areas were determined at the zip-code level using Area Deprivation Index 2019 data.

Percent of Beneficiaries With at Least One Service by Zip Codes with High Versus Low Levels of Disadvantage per Month in Maryland 2020 Medicare Claims



Notes: Maryland Medicare claims data from 2020 was utilized to identify the percent of unique beneficiaries with at least one service or at least one telehealth service per month. Disadvantaged areas were determined at the zip-code level using Area Deprivation Index 2019 data.

Appendix E: Claims Payor Billing Codes

Table 3 CareFirst – Procedure and Diagnostic Codes to Identify Types of Telehealth Services by Modality

Modality	Modifier (GT or MOD 95) and POS = 2	Modifier GT and POS = 2	POS 02	No MOD or POS
Both	90785; 90791-90792; 90832-90834; 90836-90838; 90845-90847; 90849; 90863;92507; 93268; 93270-93272; 96040; 96116; 96121; 97802-97804; 98960-98962; 99211-99215; 99307-99310;99354-99355; 99401-99409; 99496; 97530; S9443	96160-96161; 99497-99498	CPT codes: 92508; 92521-92524; 92626-92627; 92630; 92633; 96105; 96125; 97110; 97112; 97129-97130; 97161-97162; 97164-97165; 97535 **OR** ICD-10 Diagnostic Codes: Z20.828; U07.1	G2025
Audio-visual only	90853; 90951-90952; 90954-90955; 90957-90958; 90960-90961; 90964; 90966; 90968; 90970; 92526; 92227-92228; 93228-93229; 96110; 96130-96132; 96136-96137; 97530; 99201-99205; 99221-99223; 99231-99233; 99241-99245; 99251-99255; 99341-99345; 99347-99350; 99495; 99341-99350	90965; 90967; 90969; 97151; 97155-97157	97153; 97166; 97168; 97533; 99381-99387; 99391-99397	
Audio-only				99441-99443

Table 4 Cigna – Procedure and Diagnostic Codes to Identify Types of Telehealth Services by Modality

	Modifier GT, 95	Modifier GQ	No Modifier
Audio-visual only	96040; 99202-99205; 99211-99215; 99406-99409; G0108; G0396-G0397; G0438-G0439; G0442-G0447; G0459; G0513-G0514; 96116; 96156; 96158-96161; 96164-96165; 96167-96168; 90951-90970; 97802-97804; G0270; 97110; 97112; 97161-97168; 97530; 97755; 97760-97761; 92507-92508; 92521-92524; 92601-92604; S9152; Z03.818, Z20.822, Z20.828, U07.1, J12.82, M35.81, M35.89		
Audio-only		96040; 99202-99205; 99211-99215; 99406-99409; G0108; G0396-G0397; G0438-G0439; G0442-G0447; G0459; G0513-G0514; 96116; 96156; 96158-96161; 96164-96165; 96167-96168; 90951-90970; 97802-97804; G0270; 97110; 97112; 97161-97168; 97530; 97755; 97760-97761; 92507-92508; 92521-92524; 92601-92604; S9152; Z03.818, Z20.822, Z20.828, U07.1, J12.82, M35.81, M35.89	99441-99443; G2012

Table 5 Kaiser – Procedure and Diagnostic Codes to Identify Types of Telehealth Services by Modality

	Modifier GT, GQ or 95 OR POS = 2, 10	No Modifier
Both	93228-93229; 93268; 93270-93272; 93298; 96040; 98960-98962; 99201-99205; 99211-99215; 99241-99245; 99251-99255; 99381-99387; 99391-99397; 99401-99404; 99468-99469; 99497-99498; G0296; G0406-G0408; G0438-G0439; G0459; G0506; G0508-G0509; G0513-G0514; G2061-G2063 ; 99217-99226; 99231-99236; 99238-99239; 99281-99285; 99291-99292; 99354-99357; 99471-99473; 99475-99480; G0425-G0427; 96160-96161; 77427; 90791-90792; 90832-90834; 90836-90840; 90845-90847; 90853; 90863; 96116; 96121; 96130-96133; 96136-96139; 96156; 96159; 96164-96165; 96167-96168; 97151; 97155-97157; 99046-99409; 99483; G0396-G0397; G0442-G0447; G2086-G2088; 90951-90955; 90957-90970; G0420-G0421; 92526; 92507; 92521-92524; 92227-92228; 97110; 97112; 97116; 97161-97164; 97530; 97535; 97750; 97755; 97760-97761; 97110; 97112; 97165-97168; 97530; 97760-97761; 97802-97804; G0108-G0109; G0270; 99304-99310; 99315-99316; 99327-99328; 99334-99337; 99341-99350	
Audio-only		98966-98968; 99441-99443

Table 6 UnitedHealth Care – Procedure and Diagnostic Codes to Identify Types of Telehealth Services by Modality

	POS = 2 or POS = 10	No Modifier
Audio-visual only	93228-93229; 93268; 93270-93272; 96040; 98960-98962; 99202-99205; 99211-99215; 99395-99397; 99406-99409; 99483; 99495-99498; G0108-G0109; G0296; G0406-G0408; G0425-G0427; G0438-G0439; G0506; G0513-G0514; G2211-G2212; 99217; 99224-99226; 99231-99233; 99238-99239; 99281-99285; 99291-99292; 99356-99357; 99469; 99472; 99476; 99478-99480; G0459; G0508-G0509; 96160-96161; 90785; 90791-90792; 90832-90834; 90836-90840; 90845-90847; 90863; 90853; 96116; 96121; 96130-96133; 96136-96139; 96156; 96158-96159; 96164-96165; 96167-96168; 99354-99355; G0396-G0397; G0442-G0446; G2086-G2088; G9978- G9986; 90951-90970; G0420-G0421; 92227-92228; 99334-99337; 99347-99350; G9489; 97802-97804; G0270; G0447; 99307-99310; 99315-99316; 97110; 97112; 97116; 97161-97168; 97530; 97535; 97750; 97755; 97760-97761; 97110; 97112; 97165-97168; 97530; 97535; 97750; 97755; 97760-97761; 92507; 92521-92524; 92526; 96105; 97129-97130; 99201; 99203-99205; 99211-99213; 97110; 97112; 97116; 97530; 97535; 97750; 97755; 97760-97761	
Audio-only		99441-99443;
Both		G2012, G2251
Other	99421-99423; 98970-98972	

Table 7 Aetna – Procedure and Diagnostic Codes to Identify Types of Telehealth Services by Modality

	Modifier GT or 95 or FR	Modifier GT or 95 or FR or FQ or 93	No Modifier
Both	90849; 90951; 90952; 90954; 90955; 90957; 90958; 90960; 90961; 90963 - 90970; 92227; 92228; 93228; 93229; 93268; 93270 - 93272; 96040; 98960 - 98962; 99202-99205; 99211-99215; 99241-99245; 99251-99255; 99408; 99409; 99417; 99495; 99496; G0438; G0439; 90785; 90791; 90792; 90832-90834; 90836-90840; 90845-90847; 90853; 90863; 96116; 96160; 96161; 97802-97804; 99354 - 99357; 99406; 99407; 99497; 99498; G0108; G0109; G0270; G0296; G0396; G0397; G0442 - G0447; G0459; G0506; G0513; G0514; G2086-G2088; G2212	90785; 90791; 90792; 90832-90834; 90836-90840; 90845-90847; 90853; 90863; 92507; 92508; 92521 - 92524; 96116; 96121; 96127; 96130-96133; 96136-96139; 96158-96161; 96164; 96165; 96167; 96168; 97535; 97802-97804; 99354 - 99357; 99406; 99407; 99497; 99498; G0108; G0109; G0270; G0296; G0396; G0397; G0442 - G0447; G0459; G0506; G0513; G0514; G2086-G2088; G2212	96156; 98966 - 96968; 99441 - 99443; 99446 - 99449; 99451; 99452; G0406-G0408; G0425-G0427; G0508; G0509; G0406-G0408; G0425-G0427
Audio-visual only	77427; 90875; 90953; 90956; 90959; 90962; 92002; 92012; 92065; 92526; 92601 - 92604; 92606; 92609; 93750; 93798; 94625; 94626; 94664; 95970 - 95972; 95983; 95984; 96110; 96112; 96113; 96125; 96170; 96171; 97110; 97112; 97116; 97129; 97130; 97150; 97151; 19153; 97155; 97156; 97157; 97161-97168; 97530; 97542; 97755; 97760; 97761; 99217 - 99226; 99231-99236; 99238; 99239; 99281-99285; 99291; 99292; 99304-99310; 99315-99316; 99327; 99328; 99334-99337; 99341-99345; 99347-99350; 99468; 99469; 99471; 99472; 99475-99480; 99483; G0410; G0422; G0423; G0424; H0015; H0035; H0038; H2012; H2036; S9443; S9480		
Other			G2010; G2012; G2061 - G2063; G2250 - G2252; 98970 - 98972; 99421 - 99423

Appendix F: 2020 Commercial & Medicaid Claims Services by Modality

Table 8 Commercial Payors: 2020 Percent of E&M Services by Modality

Modality	Total Percent per Modality
In-person	88%
Audio-visual/Audio-only	7%
Audio-visual	2%
Audio-only	3%
Other Telehealth	0%

Notes: This table denotes the modalities that all commercial payors prefer with in-person being the top choice (88%).

Table 9 Commercial Payors: 2020 Percent of Telehealth E&M Services by Modality

Telehealth Modality	Total Percent of Services per Modality
Audio-visual/Audio-only	60%
Audio-visual	16%
Audio-only	24%
Other Telehealth	0%

Table 10 Medicaid: 2020 Precent E&M Services by Modality

Modality	Percent of Services
In-person	81%
Audio-visual/Audio-only	0
Audio-visual	15%
Audio-only	4%
Other Telehealth	0

Notes: This table shows the modalities that all Medicaid users prefer with in-person being the top choice (81%).

Table 11 Medicaid: Percent of Telehealth E&M Services by Modality

Telehealth Modality	Percent of Services
Audio-visual/Audio-only	-
Audio-visual	79%
Audio-only	21%
Other Telehealth	-

Appendix G: 2021 Commercial & Medicaid Claims Services by Modalities

Table 12 All Commercial Payors: Percent of E&M Services by Modality

Modality	Total Percent per Modality
In-person	88%
Audio-visual/Audio-only	7%
Audio-visual	3%
Audio-only	2%
Other Telehealth	0

Table 13 Medicaid: Percent E&M Services by of Modality

Modality	Percent of Services
In-person	84%
Audio-visual/Audio-only	0
Audio-visual	13%
Audio-only	3%
Other Telehealth	0

Table 14 Commercial: Percent of E&M Services by Modality

Telehealth Modality	Total Percent per Modality
Audio-visual/Audio-only	57%
Audio-visual	29%
Audio-only	14%
Other Telehealth	0%

Table 15 Medicaid: Percent of E&M Services by Modality

Telehealth Modality	Percent of Services
Audio-visual/Audio-only	-
Audio-visual	79%
Audio-only	21%
Other Telehealth	-

Appendix H: Consumer Interview Demographics

Exhibit F: Consumer Interview Participant Demographics

Participants | We interviewed 78 individuals across the four regions. The interviewees were younger and included more females than the general population, yet there was sufficient representation based on other demographic characteristics.

	Total	Baltimore City	Eastern Shore	Prince George / Montgomery County	Western Maryland
Language					
English	74	19	18	18	19
Spanish	4	-	3	1	-
Telehealth Use Status					
User	68	16	20	17	15
Non-User	10	3	1	2	4
Age*					
18-39	36	13	5	9	9
40-64	24	2	10	5	7
65+	12	2	3	4	3
Gender*					
Female	50	11	16	10	13
Male	24	8	2	8	6
Income*					
Under $35,000	12	4	3	2	3
$35,000 - $75,000	30	9	8	5	8
Over $75,000	20	3	5	6	6
Do not wish to disclose	11	3	2	5	2
Race/Ethnicity*					
Asian	4	-	-	2	2
Black/African American	26	11	3	8	4
White	40	5	15	7	13
Other	4	3	0	1	-

NOTES: *Only available for English speakers due to privacy limitations of our recruitment approach.

Appendix I: The Maryland Insurance Administration ("MIA") Report

Introduction

The Maryland Insurance Administration ("MIA") is required by the Preserve Telehealth Access Act of 2021 ("the Act") to conduct a limited-scope study of telehealth and insurance coverage, and then provide the MIA findings to the Maryland Health Care Commission for inclusion in a comprehensive telehealth report due to the General Assembly on December 1, 2022. Specifically, the MIA is required to study:

how telehealth can support efforts to ensure health care provider network sufficiency; and
the impact of changes in access to and coverage of telehealth services under health benefit plans offered by health insurance carriers on the ability of consumers to choose in–person care versus telehealth care as the modality of receiving a covered service.

The MIA is also required to consider the requirements of the Act when proposing any revisions to regulations relating to network adequacy.

As background, House Bill 1318, Chapter 309, Acts of 2016 established specific standards and requirements for health care provider networks used by carriers in the private insurance market, and required the MIA to adopt regulations by December 31, 2017 to establish quantitative and, if appropriate, non-quantitative criteria to evaluate the network sufficiency of health benefit plans. House Bill 1318, at § 15-112(d)(2)(viii) of the Insurance Article, specifically authorized the MIA to take telemedicine and telehealth into consideration in adopting the regulations. The network adequacy regulations finalized by the MIA at COMAR 31.10.44 include a general statement that carriers are permitted to consider telehealth utilization as part of meeting appointment waiting time standards when telehealth is clinically appropriate and an enrollee elects to use it.[46] The regulations also require carriers to identify in the network adequacy access plan executive summary form whether telehealth appointments were counted as part of the appointment waiting time standard results.[47] The regulations do not otherwise take telemedicine and telehealth into

[46] COMAR 31.10.44.05A(2).

[47] COMAR 31.10.44.09A(2)(b).

consideration, and do not provide any guidance to carriers on how to operationalize the provision allowing telehealth to be counted toward the appointment waiting time standards.

The MIA's experience reviewing network access plans submitted by carriers in the years following the effective date of the network adequacy regulations revealed several areas where the existing regulations could be improved, and additional areas where further regulatory action was warranted. Of particular note, the regulations did not establish uniform methodologies for measuring the standards, and this presented challenges in accurately evaluating the sufficiency of carrier provider networks, and in ensuring appropriate enforcement of the existing standards. To address these issues, the MIA reconvened its network adequacy workgroup in the fall of 2019, and began working on revisions to the existing regulations. The workgroup's progress was slowed due to the COVID-19 public health emergency and other regulatory priorities, but prior to the enactment of the Act, the MIA held five public hearings to discuss proposed revisions to COMAR 31.10.44, and exposed a pre-publication draft of the proposed revisions for public comment on November 4, 2020.[48]

One of the many important issues analyzed by the workgroup was how to improve the provisions of the regulation addressing telehealth. Representatives of carriers requested greater allowances for the use of telehealth to satisfy network adequacy standards, noting the pressure exerted on them by regulatory agencies, consumers, and providers to expand coverage of telehealth services during the public health emergency. Consumer advocates, on the other hand, expressed hesitation with the idea of changing the telehealth provisions, citing concerns with accessibility and availability of telehealth, as well as consumer preference for in-person services. While there was robust discussion from stakeholders related to telehealth, no concrete proposals for how to amend the telehealth provisions were offered. For this reason, among the other proposed amendments in the November 2020 draft, the MIA included a "placeholder" telehealth clause[49] that was intended to spur discussion around the MIA's suggestion that telehealth services that are clinically appropriate, available, and accessible to an enrollee should be considered when determining, on the aggregate, whether a carrier's provider network is sufficient to meet the needs of enrollees.

The MIA evaluated the public comments received on the November 2020 draft, and continued to analyze how to better leverage the potential for telehealth to enhance enrollees' access to in-network care without jeopardizing enrollees' access to in-

[48] See Appendix A for the complete November 4, 2020 draft regulation.

[49] COMAR 31.10.44.06B(3) in the November 4, 2020 draft regulation states "When a telehealth appointment is clinically appropriate, available, and accessible to an enrollee, a carrier may consider the offer of that appointment as a part of its meeting the [appointment waiting time] standards."

person services. The Act was signed into law a few months later, temporarily codifying some of the telehealth accommodations carriers had voluntarily implemented during the public health emergency, and imposing additional requirements on carriers related to telehealth. During the ensuing year and a half, in consideration of the requirements of the Act, the MIA re-evaluated the role of telehealth in the network adequacy context and studied the impact of changes in access to and coverage of telehealth services on the ability of consumers to choose in–person care versus telehealth care as the modality of receiving a covered service.

To gather information on changes in access to and coverage of telehealth services, the MIA examined telehealth benefits included in approved and filed Maryland health benefit plan contracts beginning with the period immediately prior to the public health emergency and ending with contracts filed in 2022 for use in plan year 2023. The MIA also initiated a data call on Maryland carriers offering health benefit plans for further details and information on the scope and availability of telehealth benefits during the same period. Additionally, telehealth-related consumer and provider complaints filed with the MIA between 2019 and 2022 were analyzed to identify potential issues and trends. Finally, to gain general insight into national developments on this topic, the MIA reached out to other state insurance regulators through the National Association of Insurance Commissioners ("NAIC") and obtained information on laws and filing trends related to coverage of telehealth services vs. in-person services in other states.

For the network adequacy component of the study, the MIA leveraged the information obtained on access and coverage of telehealth, and supplemented this with a comprehensive literature review of how telehealth is being handled in the network adequacy realm. This included research into regulations and guidance issued by state and federal governmental agencies, including other state insurance departments, Medicare Advantage, state Medicaid programs, and the Centers for Medicare and Medicaid Services ("CMS) with respect to Qualified Health Plans sold on the Federally Facilitated Exchanges. Scholarly articles on the issue of telehealth from the NAIC, educational institutions, and research firms were also reviewed for any content and analysis related specifically to network adequacy. However, the network adequacy component of the study was most significantly informed by the MIA's own experience in reviewing and analyzing trends in carrier's annual network access plans for the past five years, and in working with Maryland stakeholders to revise the existing network adequacy regulations.

Based on the above process, the MIA was able to gather information in order to analyze the requirements of the study and to perform a substantive review.

Research and Findings

I. Changes in Access to and Coverage of Telehealth Services

Review of approved and filed health benefit plan contracts

Health benefit plan contracts sold in Maryland have been required by law to provide coverage for telehealth services dating back to October 1, 2012, when Senate Bill 781, Chapter 579, Acts of 2012 became effective, adding § 15-139 to the Insurance Article. The particular coverage requirements for telehealth under § 15-139 have been amended multiple times since 2012. Under Maryland law, health insurance carriers are required to file the form of all insurance policies for review and approval by the MIA prior to marketing or selling a policy intended to be delivered or issued for delivery in the State. Consequently, the most comprehensive and accurate method of identifying and evaluating changes in access to and coverage of telehealth services under health benefit plans offered by health insurance carriers is to examine the provisions of contract forms carriers have filed for approval with the MIA. To accomplish this, the MIA performed an exhaustive review of health benefit plan forms approved or filed between 2019 and 2022.

The year of 2019 was selected as the starting point to establish a baseline for the scope of telehealth coverage immediately prior to the public health emergency, before the explosion in utilization that occurred during the pandemic. The MIA had not noted significant changes in telehealth coverage prior to 2019, so it was determined there would be minimal added value in examining contracts filed before this date. The complete time range includes the period of stay-at-home orders and medical office closures during the height of the pandemic when telehealth was often the only option for non-urgent medical care. During this time, at the urging and request of the MIA, all the health carriers implemented voluntary coverage expansions to provide benefits for telehealth services in situations where coverage had not previously been provided. The timeframe under review also covers the period after the pandemic subsided, when carriers began to evaluate and develop longer-term strategies for covering telehealth, and after the Act codified new and expanded telehealth coverage requirements under § 15-139, including certain provisions that are currently scheduled to sunset on June 30, 2023.

In analyzing approved and filed forms, the MIA took note of the types of telehealth services covered and changes to telehealth benefits over time. Particular attention was paid to the language in the forms that described and/or defined telehealth, the cost-sharing for the benefit, applicable limitations and/or exclusions, and any unique programs and/or riders that pertained to telehealth. The research examined issues such as: the different modalities of telehealth that were covered; whether telehealth services were covered when provided by telehealth-only providers or through “brick and mortar” providers who provide in-person services in addition to telehealth services, whether the carrier arranged for or required telehealth services to be covered through a designated telehealth vendor; and whether either telehealth or in-person services were incentivized over the other through exclusions, limitations, or preferential cost-sharing. The study intended to make note of any unique or innovative telehealth provisions that were filed, even if those benefits were not ultimately approved. However, no provisions meeting these criteria were

identified that were either withdrawn by the carrier or disapproved by the MIA prior to product approval. The research focused on filings in the following Maryland markets: individual non-grandfathered, small group non-grandfathered, student health, large group, and individual grandfathered.[50]

Generally speaking, the trends revealed by the study were fairly consistent across markets. However, more changes and variations in telehealth coverage were noted in the large group market than in any other market. This was to be expected, since the large group market is where there is the greatest amount of customization of benefits and negotiation between carriers and group policyholders. Overall, several trends were noted over the time period from 2019 to 2022. First, there was a dramatic shift over time from all carriers excluding audio-only telephone conversations from the telehealth benefit to expressly including them as part of the coverage. This change can be attributed to the voluntary telehealth expansions implemented by the carriers in the early part of the public health emergency, followed by the statutory change under the Act that required coverage of certain audio-only telephone conversations between July 1, 2021 and June 30, 2023. Second, there was a trend of carriers moving from including one general telehealth benefit description in the filing to including specific references to telehealth within individual benefits. The benefit-specific telehealth coverage often involved programs related to weight loss, behavioral health, substance use disorder, and complex care, and it frequently included reduced or waived cost-sharing for telehealth services. This change could reflect an effort by carriers to incentivize greater use of telehealth by highlighting telehealth benefits more prominently in contract forms. Alternatively, it could simply be a carrier response to market demand and increased consumer interest in telehealth.

In regard to cost-sharing more broadly, some of the contracts in early years included plan options with dollar maximum on telehealth services that were not applied to in-person office visits. Additionally, a shift over time was noted where carriers initially specified one separate cost-share for all telehealth services in general, but in later years began including multiple cost-sharing options for a variety of different telehealth services. In addition to allowing for greater customization of benefit options, having multiple cost-sharing options for specific telehealth services allowed carriers to cover telehealth at the same level as the comparable in-person service. For example, a contract with different specified copays for all primary care physician office visits, all specialist office visits, and all mental health and substance use disorder office visits could now have discrete copays for primary care telehealth, specialty care telehealth, and mental health and substance use disorder care telehealth, instead of covering all telehealth at the same copay. This appeared to reflect a shift from treating telehealth as a different type of service with unique cost-sharing, to treating telehealth as simply another comparable modality for the same type of service. There was also a trend in

[50] See Appendix B for a detailed summary of the findings for each year and market.

more recent filings to move from applying the same cost-share to telehealth as was applicable to similar services, to providing programs or plan design options with lower cost-sharing options for telehealth when compared to in person services. While not always the case, in many situations, the most generous cost-sharing was provided for specific designated telehealth providers or for telehealth-only providers. In considering the implications of these trends, it should not be overlooked that during the public health emergency, carriers were pressured by regulators, public health officials, and providers to encourage the use of telehealth services by enrollees, as appropriate, to reduce the likelihood of exposure to and transmission of COVID-19. Waiving or reducing cost-sharing for telehealth services was one of the few ways carriers could directly incentivize enrollees to elect telehealth. Thus, public policy recommendations in response to the COVID-19 pandemic can be seen as the primary driving force that initiated the trend for carriers to offer preferential cost-sharing for telehealth.

While the research did uncover some trends in changes to telehealth coverage as outlined above, it is perhaps more pertinent to note what was not observed in the filed forms. By and large, except for the expansion of coverage for audio-only services, no radical changes in telehealth coverage or benefits were noted during the time period under study, and most of the changes that were observed appeared to be in direct response to statutory changes, regulator requests during the public health emergency, and/or consumer and provider demand. No provisions, limitations, or exclusions were identified that restricted an enrollee's access to in-person services or impeded the ability of an enrollee to choose in-person care over telehealth as the preferred modality of service delivery and still receive coverage under the insurance policy. Additionally, except for the cost-sharing incentives previously described, there was only one provision in one policy form from a single carrier that had the potential to steer enrollees to utilize telehealth over in-person services.

The provision in question described a "virtual gatekeeper" feature where the enrollee was assigned a virtual primary care physician who would act as a gatekeeper to issue referrals to other network providers for further in-person and virtual care services, as appropriate. Initially, the language in the contract appeared to suggest that the enrollee was required to use a virtual primary care physician as the gatekeeper, essentially requiring the enrollee to utilize telehealth first before receiving in-person care. However, in response to MIA inquiries during the form review process, the carrier clarified that although the policy does require the enrollee to select a primary care physician to coordinate all care and issue referrals to other providers, enrollees are permitted to choose a non-virtual primary care provider depending on their preference. The forms were revised to clarify this issue before the contract was approved. However, the default process under the contract is that a virtual primary care physician is automatically assigned to each enrollee, and if the enrollee prefers an in-person primary care physician, the enrollee must actively select a different provider by calling the number on the enrollee ID card.

Additional noteworthy findings include the observation that in recent years, no carrier required the use of a designated telehealth-only vendor in order to receive coverage for virtual care services. This was true even before the Act codified this requirement explicitly in § 15-139 of the Insurance Article. One carrier offered a separate benefit for virtual-only providers through a designated vendor who did not offer in-person services, but this benefit was a supplement to the general telehealth benefits from providers who offer virtual services in addition to in-person services. Other carriers also made a distinction in some of their forms between services rendered by virtual-only providers and services rendered by providers who offer both telehealth and in-person services. However, both types of telehealth were clearly covered under these plans. There were, therefore, no noted limitations that would prevent an enrollee from obtaining telehealth services from any network provider willing and equipped to offer virtual services. The research also revealed that, for the most part, the contracts did not specifically address the different modalities of telehealth, and limited the description of the coverage to the statutory definition of telehealth from § 15-139 of the Insurance Article. In the rare situations where additional telehealth modalities were specifically referenced, it was in the context of exclusions for electronic vital sign monitoring and telemedicine kiosks. These exclusions only appeared in a handful of contracts.

In general, the review of approved and filed health benefit plan contracts indicated that telehealth benefits have expanded to encompass more forms of communication, and that carriers have become more innovative in the way they implement cost-sharing options for telehealth benefits. Telehealth usage was incentivized over in-person services in certain situations through the application of lower cost-sharing for telehealth, which, in some cases, was only available through specific designated telehealth providers. Furthermore, during the time period under study, carriers developed various programs that included or were centered around telehealth services. However, the expansion of coverage for telehealth was not accompanied by any noticeable restriction or reduction of coverage for in-person services.

Health Carrier Survey on Telehealth Coverage

Many of the details and specifics of how benefits are administered in practice are not always evident from the benefit descriptions on the policy forms. For this reason, to supplement and verify the information obtained from the review of carrier contracts, the MIA conducted a confidential survey of the health carriers to gather additional information on the scope and availability of telehealth benefits. The survey inquired about the extent of coverage for telehealth currently and prior to 2020. Information was requested on all five modalities of telehealth (real-time audio/visual, real-time audio-only, remote patient monitoring, store and forward services, and mobile health). Carriers were also asked about the types of providers eligible for reimbursement of telehealth, the types of covered or offered platforms or alternative delivery methods for telehealth, whether the carrier offers any products that incentivize the use of telehealth over in-person services, and whether any products are in

development that would require the use of telehealth under any circumstances. Finally, carriers were asked to provide any readily available data on the number and percentage of in-network providers who offer telehealth.[51]

Responses were received from 16 different health carriers, representing seven distinct corporate groups across all the same markets that were examined during the contract review phase of the study. In general, the survey responses confirmed the findings from the review of approved and filed contracts. For example, the surveys demonstrated that carriers did not cover audio-only telehealth services prior to 2020, that there was a recent trend toward more comprehensive coverage of telehealth, and that nearly all carriers were offering plans as of 2022 that included preferential cost-sharing for some or all telehealth services. The surveys also confirmed that all carriers currently covered telehealth provided by traditional "brick and mortar" providers who rendered in-person services in addition to virtual services. Most carriers also included "telehealth-only" providers in their networks, though some of the carriers with smaller Maryland market shares indicated that they did not contract with "telehealth-only" providers.

The surveys responses indicated greater use of proprietary telehealth platforms and telehealth-only vendors than was evident from the review of health benefit plan contracts alone, but again, these were offered as supplements to otherwise available telehealth benefits, and were not required to be accessed in order to receive coverage of telehealth. All carriers were clear that telehealth services provided through any generally available, non-public facing platform that satisfied current guidance under federal HIPAA privacy laws would be covered. Some carriers provided access to a national network of virtual care providers authorized to provide telehealth services in all 50 states, which created clear benefits as well as potential drawbacks for Maryland patients. On the one hand, providers located in geographically dispersed states would not be available to provide in-person services to Maryland patients. Therefore, these providers would not always meet the needs of patients wishing to utilize the hybrid form of treatment where the same provider alternatively provides in-person services and virtual services depending on the circumstances of the particular visit. On the other hand, a national virtual care network can greatly enhance access to care by providing Maryland patients who wish to receive telehealth services with access to a significantly greater number of qualified providers than would otherwise be available based on the supply of practicing providers with physical offices located in Maryland. For certain specialties where there is high demand or a shortage of licensed practicing providers, this can be a considerable benefit. It is also important to note that carriers who offer this national network of virtual care providers still cover telehealth services performed by traditional "brick and mortar" providers.

[51] See Appendix C for the complete template for the carrier survey.

The survey also afforded much greater insight into the scope of coverage for the different modalities of telehealth than was obtained from the review of the contracts. The majority of carriers covered only real-time audio/visual telehealth prior to 2020 and cover only real-time audio/visual and real-time audio-only currently. A significant number of carriers, however, also indicated that they cover remote patient monitoring and store and forward services, even though these modalities were not expressly described in the benefit contracts that were reviewed by the MIA. "Remote patient monitoring" describes a process that uses technology to collect personal medical data from a patient at one location and electronically transmit the data to a provider at another location to monitor and manage the patient's condition.[52] [53] It is often used with particular acute and chronic conditions, such as high blood pressure, diabetes, and obesity, and it leverages various medical monitors and devices to collect the data. "Store and forward" refers to an asynchronous modality of telehealth where health history or other medical information, such as imaging, is transmitted electronically to a specialist provider to evaluate a patient or provide a service outside of a real-time encounter.[54] Because store and forward does not involve live interactions between the patient and provider, these services do not typically fall under the definition of "telehealth" in § 15-139 of the Insurance Article, which means carriers are not currently required to cover these services.

Generally, coverage for both remote patient monitoring and store and forward increased between 2019 and 2022, but most carriers still only cover these services on a limited basis or for particular conditions only. A few carriers have also begun offering limited benefits for mobile health, which refers to online services and mobile phone apps that provide health care support that is separate from the services covered by the other modalities of telehealth (i.e., real-time audio/visual telehealth, real-time audio-only telehealth, remote patient monitoring, or store and forward).[55] A somewhat unexpected finding from the carrier surveys was that all the telehealth benefits and modalities that were offered by the various carriers across the entire time period were included in products as standard benefits, rather than as optional or specialty product offerings. This was true even of the services that are not expressly required by be covered under § 15-139 of the Insurance Article.

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[52] "What is Telehealth." *Center for Connected Health Policy,* www.cchpca.org/what-is-telehealth/.

[53] Marcoux RM, Vogenberg FR. Telehealth: Applications From a Legal and Regulatory Perspective. P T. 2016 Sep;41(9):567-70. PMID: 27630526; PMCID: PMC5010268. National Library of Medicine, National Center for Biotechnology Information, www.ncbi.nlm.nih.gov/pmc/articles/PMC5010268/.

[54] *Ibid.*

[55] *Ibid.*

To explore one measure of the capacity of carrier networks to provide access to all the different telehealth benefits described in the contracts, the survey requested data on the number and percentage of in-network providers who offer telehealth, broken down by type of provider and geographic region. However, the survey directed carriers to only provide data that could be readily generated without additional system programming on the part of carriers. Most of the carriers responded that they did not track the particular data being requested, or they had just recently begun collecting provider level data and were not yet able to report results. For this reason, carrier data on telehealth utilization by provider type and geographic region was sparse, and caution should be exercised in drawing any conclusions from what was reported.

One large carrier group reported that in 2021, claims data showed that 46% of in-network providers with unique tax identification numbers delivered at least one telehealth visit to a commercial enrollee. Conversely, another carrier with a small market presence in Maryland stated that they were only able to confirm that 2.2% of their in-network providers in Maryland currently have telehealth availability. A third carrier was not able to report data at the provider level, but did indicate that telehealth represented 10% of total visits during the first five months of 2022, and 50% of the telehealth visits were for mental health and substance use disorder. Lastly, one carrier was able to provide very granular information on the number (but not percentage) of in-network providers within various specialties who offer telehealth, and was also able to report on the number of providers by specialty who actually submitted telehealth claims in 2021 and in the first five months of 2022. Overall, in 2021, this carrier had more than 6500 telehealth-only providers in the urgent care/general health category, more than 100 telehealth-only providers in the preventive care/well visits category, and over 5500 telehealth-only providers in the behavioral health category. These numbers are in addition to the carrier's in-network providers who can provide in-person services as well as virtual services.

Looking specifically at telehealth utilization by specialty in 2021 for all Maryland providers in this last carrier's network, the carrier reported telehealth claims from more than 1500 different Internal Medicine providers and over 1300 Family Medicine providers. There were 21 other provider specialty categories where the provider count for telehealth utilization was between 100 and 750 providers, 32 provider specialty categories where the provider count was between 20 and 99, and an additional 78 provider specialty categories where the provider count was between 1 and 19. Following Internal Medicine and Family Medicine as the specialties with the highest provider counts for telehealth utilization were: Pediatrics, Nurse Practitioners, Obstetrics/Gynecology, and Family Nurse Practitioners/Primary Care. Somewhat surprising was that the provider counts for behavioral health specialties were on the low end of the scale, with eight distinct categories of behavioral health care providers with counts in the range from 30 to the single digits. It should be noted that many patients receive basic treatment for behavioral health conditions from their primary care providers, so the high provider counts in the general practitioner categories referenced above likely included a significant number of behavioral health services. The data reported by the carrier for the first five months of 2022 demonstrated comparable trends to the 2021 data.

In sum, the carrier data call supplemented the information obtained from the review of carrier contracts, and provided additional evidence that access to telehealth services has been increasing under Maryland insured plans in recent years. Factors contributing to the increased access include coverage of additional modalities of telehealth, approval of non-proprietary platforms for the delivery of telehealth, and the addition of telehealth-only vendors to carrier networks to supplement the telehealth services offered by traditional brick and mortar providers. As with the analysis of health benefit contract forms, the carrier surveys did not provide any evidence that changes in telehealth coverage in Maryland have resulted in any restrictions on the availability of in-person services. However, one carrier did acknowledge in their survey response that they are currently offering a product in certain markets nationally that is a true "virtual first" model that requires the enrollee to select a virtual primary care physician to direct all subsequent care. As noted above, there is a version of this product that was filed and approved in Maryland, but the Maryland product still allows an enrollee to select an in-person primary care physician if that is preferred over the virtual option.

Analysis of Telehealth-Related Complaints from Consumers and Providers

In addition to evaluating the contractual provisions related to telehealth in carriers' policy forms and requesting information from carriers on the administration of telehealth benefits, the MIA determined that complaint data related to telehealth would also be instructive for studying whether and how changes in telehealth benefits may impact the ability of consumers to choose in-person care over virtual care. The MIA's complaint tracking system uses various codes to identify particular types of complaints, and although there are a limited number of classification codes currently in use, a separate code for telehealth has been in use for many years. The MIA was therefore able to analyze all telehealth-related consumer and provider complaints against health carriers received between January 1, 2019 and June 30, 2022 to examine whether there were any complaint trends associated with the changes to telehealth benefits that began during the public health emergency.[56]

During the time period under review, the MIA received at total of 11,522 complaints, and only 30 of these complaints were coded as having a telehealth component. Additionally, out of the total number of complaints, 3,003 were complaints based on an adverse decision rendered by a carrier, which is a determination by the carrier that a proposed or delivered health care service is not medically necessary, appropriate, or efficient. None of the adverse decision complaints received during this time period were related to telehealth, and this was unexpected because § 15-139(h) of the Insurance Article specifically provides that a carrier's

[56] See Appendix D for a chart identifying all of the telehealth complaints with basic coding information.

decision not to provide coverage for telehealth constitutes an adverse decision, if the decision is based on a finding that telehealth is not medically necessary, appropriate, or efficient. Consequently, during the period under review, no consumer or provider complained to the MIA that a carrier had refused to cover telehealth on the grounds that it was not medically appropriate to provide the service via telehealth.

The 30 telehealth complaints received represented only 0.26% of all complaints received by the MIA's Life and Health Division during this time period. Of the 30 complaints, the MIA ultimately had no jurisdiction over 11 of the cases. This was because those cases involved plans not regulated by the MIA, including self-funded state and federal government employee plans, self-funded private employer plans, and plans issued in a state other than Maryland. For the remaining 19 cases where the MIA had jurisdiction, one complaint was received in 2019, 14 complaints were received in 2020, four complaints were received in 2021, and no complaints were received in the first six months of 2022. Four of the complaints involved plans sold in the individual market, and all the remaining complaints involved plans sold in the group market.

Overwhelmingly, the most frequently cited issue in the complaints was the denial of coverage for audio-only consultations. Ten of the complaints where the MIA had jurisdiction involved audio-only telehealth. Five of these complaints were submitted by the same consumer about different claims, but even if the multiple complaints by this consumer are excluded, complaints related to audio-only telehealth still outnumbered all the other types of telehealth complaints received during the time period. All of the audio-only complaints involved claims that predated the effective date of the Act, and six of them involved pre-pandemic dates of service. The four complaints related to services received during the pandemic were all filed against the same carrier. Although this carrier was voluntarily covering audio-only telehealth during the pandemic and prior to the effective date of the Act, the coverage provided was very limited and was only available for particular provider specialties. Because all of the audio-only complaints related to services that were provided prior to the effective date of the Act, the carrier's position was substantiated in every case, and the denials were upheld.

Apart from the audio-only complaints, other issues raised by multiple complainants included reimbursement rates for telehealth, and coverage of telehealth for particular specialist services, including physical therapy and mental health and substance use disorders. Some of the cases were simply inquiries from consumers and providers about the scope of coverage for telehealth during the public health emergency and how long the expanded telehealth benefits would be available. The controversies over reimbursement were generally the result of improper billing or misinformation, and the providers and carriers reached a settlement in most cases. Typically, the provider was seeking higher reimbursement or reimbursement parity with in-person services and initially believed they were not receiving this. For some of the reimbursement cases and cases involving coverage for particular specialists, the complainants' allegations of underpayment or claim denials were never actually

substantiated. However, the issues raised in the complaints still demonstrate the general consumer and provider push for expansion of telehealth coverage in additional circumstances, and higher reimbursement for telehealth services.

For the no-jurisdiction complaints, although the ultimate resolution and determination by the governmental entity having jurisdiction was unknown, the initial reasons for these complaints may provide some level of insight into telehealth issues occurring in the insurance market overall. Generally, the issues raised in the no-jurisdiction cases were the same as the issues summarized above. There were complaints about denials for audio-only coverage, complaints about denials for particular telehealth services including mental health and substance use disorder services, requests for greater telehealth access in general, and inquiries from providers regarding end dates for the expanded telehealth coverage provided during the public health emergency.

Although the total population of telehealth complaints during the time period under study was small, it is striking that all the complaints that were received related to requests for greater access to telehealth services and expansion of telehealth coverage. Conspicuously absent were any complaints alleging loss of or reduced access to coverage for in-person services, or concerns with consumers and providers being steered toward telehealth and away from in-person services against their will. The limited complaint data demonstrated universal consumer and provider desire for greater telehealth coverage in the insured market, and provided no indication that changes in telehealth benefits to date have negatively impacted the ability of consumers to choose in-person care over virtual care as the desired modality of receiving a covered service.

The National Perspective

While local developments related to telehealth coverage under insurance policies issued in Maryland are most relevant to the study requirements of the Act, national trends on changes in access to and coverage of telehealth services are also informative, and may signal potential changes that could be on the horizon in Maryland. Although fewer study resources were devoted to the national picture, the MIA did request information from other state insurance regulators through various NAIC channels. MIA questions were posted on the NAIC Market Regulation Bulletin Board, and NAIC staff also emailed the questions to all state health insurance regulator contacts on the NAIC listserv on behalf of Maryland. Additionally, the questions were verbally posed on the NAIC's weekly health care reform update call.

Information was requested on whether, since the onset of the pandemic, other states had noted an increase or expansion of telehealth benefits in product filings in the commercial insured market. The MIA specifically inquired about whether any filings were received from carriers that required the use of telehealth for certain services or under certain circumstances, either in lieu of

in-person services, or as a "telehealth-first" requirement. Additionally, states were asked whether any filings were received from carriers that incentivized the use of telehealth services over in-person services for any situations, medical conditions, or particular covered services, including waived or preferential cost-sharing, waiver of an otherwise applicable benefit limitation or exclusion, reduced administrative requirements, or prompter service. Finally, states were asked whether there were any existing laws that expressly permit, prohibit, or limit any of the product features described in the earlier questions.

In total, only ten states formally responded to the MIA inquiries, and not every state responded to all the questions posed by the MIA.[57] Due to the low response rate, the findings in this section may or may not be reflective of the most common national trends, but they do illustrate the experiences of states in several different areas of the country. Eight different states provided information on trends in increased or expanded telehealth benefits since the beginning of the pandemic. Most of these states indicated that there was an increase in coverage for telehealth services due to the pandemic, and that the increase was due to previously existing telehealth mandates and new mandates related to telehealth. Responses were generally consistent in indicating that telehealth benefits in the respective states are offered to the same extent as other benefits. There was only one state that responded that they had not noted an expansion of telehealth benefits in the market.

Eight states also responded to the question about products that required the use of telehealth in lieu of in-person services, or as a "telehealth-first" requirement. The MIA inquired about the status of any such filings to see if the products were approved or rejected by states. With the exception of one state, all other states had not received a "telehealth-only" or "telehealth-first" filing. One state approved a telehealth-first gatekeeper plan in which enrollees are required to see a primary care provider via telehealth in order to obtain referrals to receive coverage of other services. This telehealth-first policy is a small group product offered by a subsidiary of a national carrier group that does not currently offer health benefit plan products in Maryland. This was a different carrier than the Maryland carrier who disclosed to the MIA in the carrier surveys that they were offering telehealth-first products in select national markets.

Of the remaining seven states who had not received a telehealth-only or telehealth-first filing, most indicated that they would not approve this type of filing based on the state's current statutes. One state explained they would not approve these filings because their statutes require a managed care plan's provider network to have providers within 30 minutes or 30 miles of an enrollee's place of residence, and they interpreted this network adequacy requirement as prohibiting these types of plan designs. Another state said they would not approve this type of arrangement because their law requires the enrollee to be seen in

[57] See Appendix E for a summary chart of the responses from other states.

person once a year. In yet another state's statue, there is language that says "A health care provider shall not be required to document a barrier to an in-person visit nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services." A fourth state's telehealth statute provides a list of requirements that carriers are prohibited from imposing on enrollees or providers. Examples of these restrictions include but are not limited to: a carrier cannot require that in-person visit occur before telehealth care is provided; a carrier may not require patients, health care professionals, or facilities to prove or document a hardship or access barrier to an in-person consultation for coverage and reimbursement of telehealth services; and a carrier may not require the use of telehealth services if deemed not appropriate by the provider or if the patient chooses an in-person consultation. The remaining states either did not recall seeing these types of plans, or they replied "no" without a detailed explanation.

Eight different states responded to the question about filings that appeared to incentivize telehealth services over in-person services. Again, the MIA inquired about the status of any such filings to see if the products were approved or rejected by states. Out of the responses, six of the states indicated they had not received filings that appeared to incentivize telehealth services over in-person services. One of these states added that their law dictates that cost-sharing for telehealth services must be at the same amount and required under the same circumstance as in-person services, so state law would not allow approval of this type of filing. A couple of the states indicated that they had conversations with carriers about the option of a lower cost-share for telehealth services than in-person services, but they had not received any filings to date. There were only two states that said they approved filings that had a reduced cost-share or no cost-share for telehealth services when compared to in-person services. We did not receive any response that indicated a state disapproved of a filing that incentivized telehealth over in-person.

Finally, eight different states responded to the question about whether there were existing laws that expressly permit, prohibit, or limit the plan designs described in the previous questions. There were three states that said they have laws that prohibit a carrier from requiring in-person services prior to receiving telehealth services, and that carriers also cannot require enrollees to use telehealth services. One of these states has a law that prohibits a carrier from requiring an enrollee to use a separate panel of health care providers for telehealth services. A fourth state has a law that allows an enrollee to decline telehealth services, if they prefer the services be provided in person. Another state responded by saying that the enrollee must be allowed to select any provider to obtain services, but the state did not have any specific requirements related to telehealth providers.

In regard to telehealth incentives, there are two states that have laws that state telehealth services have to be covered at the same as or at a more beneficial cost-share than the same services provided in person. These cost-sharing requirements do

not appear to prohibit a carrier from providing a lesser cost-share to enrollees to incentivize telehealth services. However, there was one state that has a statutory requirement that says the carrier cannot impose a copayment, coinsurance, and deductible on telehealth services that is not "equally imposed" on other services. That state law did not specify that a lower cost-share was permitted for telehealth, so it appears there may not be an allowance for a cost-share incentive for telehealth services under that state's laws. Another state did not provide a copy of their law, but did respond (as mentioned above) that their law would not allow a telehealth incentive because of a parity requirement for telehealth services to be covered to the same extent as in person services.

Based on the responses the MIA received from other states, national trends seem largely consistent with the experience in Maryland. Multiple states have telehealth laws applicable to insurance coverage, and the majority of states noted an expansion of telehealth coverage during the public health emergency. Fewer states than anticipated acknowledged receiving filings from carriers that offer preferential cost-sharing for telehealth services, but the responses did indicate that more carriers are at least discussing these options with regulators. The revelation that a second national carrier is offering a telehealth-first gatekeeper plan may reflect an impending industry trend to push this as a new product feature. Finally, it was noted that the existing laws of some of the other states include more express prohibitions against telehealth-only and telehealth-first requirements than current Maryland law. Therefore, it appears that some other states have already taken proactive legislative steps to ensure that the recent changes in access to and coverage of telehealth services do not impact the ability of consumers to choose in-person care over telehealth care.

II. The Role of Telehealth in Supporting Efforts to Ensure Network Adequacy

History of Network Adequacy Regulations and Telehealth Reporting

Although the history of state laws addressing certain issues related to the sufficiency of health care provider networks dates back many years, comprehensive state regulation of provider networks is a fairly recent regulatory development. Once insurance regulators began placing a greater focus on network adequacy, the intersection between telehealth and network adequacy was an early consideration, though not one that received significant attention. In the fall of 2015, the full membership of the NAIC adopted the *Health Benefit Plan Network Access and Adequacy Model Act (2015 Model 74)*. This model established commonly agreed upon standards and provided a framework that states could use to form their own laws and regulations regarding network adequacy. Maryland's network adequacy statute enacted under House Bill 1318, Chapter 309, Acts of 2016 and the MIA's implementing regulations under COMAR 31.10.44 from 2017 were significantly informed by the model.

Model 74's Section 5B[58] offers examples of elements that could be reasonably used to determine network sufficiency. Telehealth is listed among them:

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

The MIA included these criteria to varying degrees in COMAR 31.10.44, which continues to be one of the most comprehensive network adequacy regulations in the nation. While many states still have only one or two quantitative metrics (and some still have qualitative standards only), Maryland's regulations set measurable standards for Section 5B items 1 – 5 of the Model, and require qualitative descriptions in network access plans for most of the remaining criteria.
Moreover, while CMS and most other states set population-based provider and distance requirements by county, Maryland sets these standards by the more granular zip code, with strict compliance levels for acceptance. Anything less than 100% for travel distance or 95% for wait times is considered deficient and subject to possible administrative action.

Regarding telehealth specifically, Maryland was one of the few states that expressly included consideration of telehealth in its network adequacy regulations. It was previously noted that COMAR 31.10.44.05A(2) allows carriers to consider telehealth utilization as part of meeting appointment waiting time standards when telehealth is clinically appropriate and an enrollee elects to

[58] "Health Benefit Plan Network Access and Adequacy Model Act (#74)", available at content.naic.org/cipr-topics/network-adequacy.

use it. If a carrier does include telehealth in the wait time standard, COMAR 31.10.44.09A(2)(b) requires carriers to "*List the total percentage of telehealth appointments counted as part of the appointment waiting time standard results*" on the public-facing executive summary. However, few carriers have elected to utilize the telehealth option to date. Because the existing regulations establish an unusually strict evidence bar at the access plan level to ensure that each telehealth appointment included in wait time metrics was chosen by the individual consumer as well as deemed clinically appropriate by the provider, companies generally had to rely on claims data if they wanted to consider telehealth when calculating the metric. It was presumed that if the visit had occurred, both the provider and patient chose this mode. This approach to telehealth operated in opposition to the general methodology in the regulations for measuring wait times, which was based on appointments "offered" by the carrier, even if the enrollee elected a later appointment.[59]

No other COMAR 31.10.44 element for network sufficiency was given such a burden of proof. The 2017 regulations generally avoided mandating specific methodologies for measuring the various required standards. This was a conscious decision by the MIA at the time the regulations were originally drafted. Because state regulation of network adequacy was so new in 2017, best practices for measuring compliance with the standards did not yet exist. By allowing carriers to use any reasonable methodology to measure the standards, the MIA had hoped to identify carrier approaches that were most effective and reliable, and then use this information to inform future refinements to the regulations. Consequently, for the standards other than telehealth, attestations from the carriers, along with appropriate justifications submitted as supporting documentation, were acceptable, whether it related, for example, to provider-enrollee ratios or the number of specialists in a particular zip code.

The practical effect of the more stringent standards related to telehealth was that only minimal credit towards meeting the waiting time standards was available to carriers in exchange for burdensome telehealth reporting and documentation requirements. Carriers, therefore, had little incentive to find an acceptable way to document patient consent and clinical appropriateness for telehealth visits when filing access plans in Maryland. COMAR 31.10.44 already required comprehensive reporting and extensive documentation to support the other standards, so it seemed that most carriers elected not to provide additional documentation for telehealth when there was no meaningful advantage for them to do so.

From the MIA's perspective, in hindsight, the executive summary disclosure requirements for telehealth in COMAR 31.10.44.09A(2)(b) were not very informative on their own, even without the burden of needing verification that the appointments were elected and clinically appropriate. As stated above, the executive summary is required to indicate the total of all telehealth

[59] COMAR 31.10.44.02B(27).

appointments counted toward the waiting time standard. A single value of estimated claims that are telehealth gives no indication of the wait times of the various appointment modalities that the patient was offered. It does not provide enough information to determine whether telehealth was chosen more often in some provider categories over the others, or if its availability was contributing to reduced wait times overall. Consequently, access plan reviewers at the MIA had to request further information to try to make such determinations, and the statistic included on the executive summary provided little value to the public.

The Covid-19 Pandemic and its Impact on Telehealth Regulations

In MIA Bulletin 20-05[60] dated March 6, 2020, the Commissioner asked carriers to *"Encourage the use of telehealth services, as appropriate, by all members to reduce the likelihood of exposure to and transmission of COVID-19."* The Commissioner also convened several meetings with the major health carriers in the early months of the public health emergency to encourage the industry to make various accommodation for consumers and health care providers during the pandemic, and many of these accommodations were related to telehealth. In response to these MIA actions and various state and federal emergency waivers of telehealth restrictions, carriers in Maryland voluntarily broadened their coverage. As described earlier in this report, some of the telehealth accommodations included providing coverage for audio-only consultations for the first time, waiving or reducing cost-sharing for telehealth, and allowing consumers and providers to use any generally available, non-public facing HIPAA-compliant platform for the delivery of telehealth.

Qualitative descriptions of how telehealth coverage was used to meet the challenges of the pandemic and expand access to care appeared in the supporting documentation of network access plans filed by carriers on July 1, 2020. However, there remained a tendency for carriers to not include telehealth in quantitative wait time metrics reported for compliance or to provide a value in the executive summary for COMAR 31.10.44.09.A(2)(b).

It is noteworthy that nationwide, there is still no widely accepted methodology to measure appointment wait times for reliable comparisons, and this continues to be an issue for states and the federal government. The 2015 NAIC Network Adequacy Model 74 did not give a recommendation, and even though CMS recently adopted new rules[61] related to network adequacy requirements for Qualified Health Plans ("QHPs") offered on Federally Facilitated Exchanges ("FFEs"), CMS elected to delay

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[60] Emergency Bulletin on Covid-19, March 6, 2020, insurance.maryland.gov/Pages/newscenter/LifeHealthBulletins.aspx.

[61] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, Final Rule, Federal Register Volume 87, Number 88 at 27208.

issuing wait time reporting requirements for FFEs until plan year 2024.[62] In Maryland, to provide justification for the reported metrics on wait times in general, carriers filing network access plans have typically submitted results of surveys to a sampling of providers as to whether the next available appointment was within the required standard for the five categories stated in the regulation.[63] These surveys vary widely in sample size, response rate, distribution method, and timeframe. Provider surveys are generally designed months in advance of implementation, and the data collected is used for the annual network access plan filing due the following July 1st. In plan years 2018 – 2020, carriers did not include specific questions identifying whether the next available appointment was in-person in their surveys, presumably because telehealth made up only a small percentage of visits when the surveys were created.

During the first year of the pandemic, carriers reported that survey response rates fell. Providers were overwhelmed with patients and hampered by office closures and staff shortages, so completing surveys was not their highest priority. The low response rates to provider surveys combined with actual longer wait times for in-person appointments due to office closures and suspension of non-urgent treatment impelled carriers to focus more efforts on including telehealth appointments when calculating the wait time metric.

Four carriers made attempts to calculate a percentage for COMAR 31.10.44.09A(2)(b) in the 2021 access plans. Each used a different method. One reported the percentage of brick and mortar locations who confirmed in a survey that they could offer telehealth. Two others reported that they used 100% of their documented telehealth appointments in the wait time standard results. However, according to the supporting documentation, they differed in how they combined claims data with their appointment availability surveys to calculate their wait time metrics. Only one carrier, whose unique business model afforded them greater insight into the scheduling practices of network providers, had access to concrete data that allowed them to report a percentage value derived from scheduling software that was most reflective of actual appointments.

In an attempt to obtain some standardization for comparison, the MIA created templates for the 2022 plan filings that included formulas for various wait time measurement methodologies and solicited expanded qualitative information about the role of telehealth in access to care in the supporting documentation. Use of the templates and the methodologies was voluntary, but

[62] "2023 Final Letter to Issuers in the Federally-facilitated Exchanges," www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf.

[63] COMAR 31.10.44.05.

yielded far more information than the single percentage calculation from the executive summary. It was clear from the templates and from the responses of the carriers to a data call done for this study that telehealth was being offered in a variety of ways that the current network adequacy regulations were not able to capture.

Emerging Telehealth Benefits in the Network Adequacy Context

One of the first identified benefits of telehealth was to extend access in situations where there are geographic or logistical barriers to receiving timely care. For example, as long as the necessary infrastructure exists to ensure telehealth is accessible to patients, telehealth provides significant value in increasing access to in-network providers in geographic areas where there are no practicing providers with physical office locations within a reasonable travel distance. Even when provider offices are reasonably close to a consumer's home based on driving distance, consumers who lack reliable transportation options to providers can greatly benefit from the ability to access in-network care in their own homes. Furthermore, as long as licensing requirements are met, the availability of telehealth across state lines has additional implications for enhancing network adequacy. Carriers who utilize a national network of telehealth providers are able to supplement the network of providers having physical offices within a particular state, which can greatly increase patient access to qualified providers in situations where there are provider shortages in that state. These benefits have the potential to help address issues with both unreasonable travel distance and unreasonable wait times.

There is general consensus that telehealth is designed to complement, not replace, in-person care, and all of the potential telehealth benefits must be viewed in the lens of how telehealth can enhance and support network adequacy, without eliminating the need for in-network providers who offer in-person or hybrid services. Patient and provider acceptance of telehealth during the early months of the pandemic was originally driven by a desire to reduce the spread of COVID-19 infection. However, as time went on, a broader acceptance evolved. As virtual communications in general became more common, remote health visits did as well. As telehealth became more routine, it was often chosen even if in-person visits were available. The rapid expansion of telehealth during the pandemic revealed several other benefits related to network adequacy beyond providing safer access to healthcare during the pandemic.

1. Several studies[64] [65] have shown fewer missed appointments with telehealth visits as compared to in-person visits, possibly because of fewer issues with transportation, childcare, or time needed to take off work. Reducing appointment no-shows increases accuracy of measuring timely appointments. Reported wait times are artificially inflated due to appointment slots that are reserved for patients who ultimately fail to show. Reducing no-shows, therefore, may indirectly improve wait times.

2. While Maryland's regulations do not set standards for hours of operation, the NAIC Model 74 does include them as a reasonable criterion to measure sufficiency. While all carriers that submitted access plans in Maryland cover providers who offer both in-person and telehealth visits, many have additionally contracted with vendors or developed internal programs to offer 24/7 telehealth services to enrollees. This time-based expansion of access has served as an afterhours option for consumers beyond their regular providers' voicemail instructions to "Call 911 if this is a true emergency." This service can be helpful to consumers in situations where it is not clear to them how urgent or emergent the problem is.[66]
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3. From the emergency service providers' viewpoint, familiarity with telehealth has given the opportunity for triage processes and standards[67] [68] to be developed to direct patients to the right venue of care at the first point of contact, reducing expensive and unnecessary visits to emergency departments for those who do not need it, and relieving long wait times for those who do.[69] The same concept of leveraging telehealth as a triage mechanism to reduce emergency wait times may have applications to non-emergency appointments as well.
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[64] Drerup, Brenden, Espenschied, Jennifer, Wiedemer, Joseph, and Hamilton, Lisa. (2021). Reduced No-Show Rates and Sustained Patient Satisfaction of Telehealth During the COVID-19 Pandemic. *Telemedicine and e-Health*. Dec 2021.1409-1415. http://doi.org/10.1089/tmj.2021.0002.

[65] Muppavarapu, Kalyan, Saeed, Sy A., Jones, Katherine, Hurd, Olivia, Haley, Vickie. (2022). Study of Impact of Telehealth Use on Clinic "No Show" Rates at an Academic Practice. *Psychiatric Quarterly,* 93:689–699. doi.org/10.1007/s11126-022-09983-6.

[66] Pearl, Robert and Wayling, Brian. The Telehealth Era Is Just Beginning. *Harvard*

Business Review, hbr.org/2022/05/the-telehealth-era-is-just-beginning. Accessed 6/7/2022.

[67] Shaheen, E., Davidson, P., Mendoza, P., Tannebaum, R., Cichon, P., Earnst, D., Guyette, F., Joshi, A., Landry, K., & Sikka, N. Practice guidance for emergency telehealth and acute unscheduled care telehealth. (2020). American College of Emergency Physicians, www.acep.org/globalassets/sites/acep/media/sections/emergency-telehealth/acep-practice-guidance-for-emergency-telehealth-and-acute-unschedulel-care-telehealth-final.pdf.

[68] Kobeissi, Mahrokh M. and Ruppert, Susan D. Remote patient triage: Shifting toward safer telehealth practice. *Journal of the American Association of Nurse Practitioners,* 34 (2022) 444–451. DOI# 10.1097/JXX.0000000000000655.

[69] Natafgi, Nabil; Childers, Casey; Pollak, Amanda; Blackwell, Shanikque; Hardeman, Suzanne; Cooner, Stewart; Bank, Robert; Ratliff, Brenda; Gooch, Victoria; Rogers, Kenneth and Narasimhan, Meera. (2021) Beam Me Out: Review of Emergency Department Telepsychiatry and Lessons Learned During COVID-19. *Current Psychiatry Reports (2021) 23: 72*. doi.org/10.1007/s11920-021-01282-4.

4. Telehealth services originating at the patient's house provide a means to overcome a variety of transportation and mobility barriers. This includes consumers residing in areas lacking affordable transit options as well as those in need of frequent follow-up checks for very specialized care or rare diseases, where visits to the closest qualified provider would involve travel and overnight expenses and missed work.[70]

5. The availability of audio-only telehealth can address access barriers in some cases, depending upon the consumer's age and technology accessibility and familiarity. Johns Hopkins' Telehealth Equity Dashboard[71] indicates a preference for phones as a point of service for vulnerable populations without access to or familiarity with other forms of technology.

6. Research suggests that acceptance of telehealth increases with experience with the modality. For some, a preference to use telehealth for follow-up care often develops even if in-person care is available.[72] [73] [74] Patient preference has most often been cited as a reason to protect access to in-person services, but this finding demonstrates that patient preference for telehealth services is another factor that policymakers may need to consider. In-network access to telehealth services is becoming increasingly necessary for a carrier's provider network to be sufficient to meet the needs of enrollees.

Improving Telehealth Reporting in Network Adequacy Regulations

The failure of pre-pandemic network adequacy regulations to accurately capture the impact of telehealth on access to care revealed an area for improvement. Emergency waivers and other required and requested telehealth coverage expansions during the pandemic clearly demonstrated the importance of telehealth availability. However, many of these are no longer in effect. States across the country are considering which changes to make permanent, but there has been a hesitant "wait and see" response from many state regulators in the area of network adequacy. Telehealth coverage by carriers is broadly encouraged by

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[70] State Telehealth Policy: Summary and Findings from the Summer 2022 Webinar Series. (August 2022). Center for Connected Health Policy, www.cchpca.org/resources/.

[71] Hughes, Helen K., et al. (2021) A Process for Developing a Telehealth Equity Dashboard at a Large Academic Health System Serving Diverse Populations. *Journal of Health Care for the Poor and Underserved*, vol. 32 no. 2, 2021, p. 198-210. Project MUSE, doi:10.1353/hpu.2021.0058.

[72] Cordina, Jenny, Fowkes, Jennifer, Malani, Rupal, and Medford-Davis, Laura. (2022) Patients love telehealth—physicians are not so sure. McKinsey & Company, February 2022. www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/patients-love-telehealth-physicians-are-not-so-sure, accessed 5/25/2022.

[73] Waite MR, Diab S, Adefisoye J. Virtual behavioral health treatment satisfaction and outcomes across time. *Journal of Patient-Centered Research and Reviews,* Rev. 2022; 9:158-65. doi: 10.17294/2330-0698.1918.

[74] The Evolution of Telehealth during the COVID-19 Pandemic. A FAIR Health Brief, June 14, 2022.

regulators, but generally still not permitted to be counted toward compliance with network adequacy standards. The resulting lack of incentive for carriers to collect and share information on the role telehealth plays in access to care has presented challenges in gaining an accurate assessment of this issue.

The concern that telehealth services will supplant in-person availability is often expressed, but generally without statistics or references to evidence where this is happening. This is certainly an important area for study and close monitoring, but it should not discourage efforts to focus on telehealth in the network adequacy arena. In terms of network adequacy assessments, it is preferable for regulators to obtain data from carrier access plan filings that fully represents what in-network services are actually available, in-person as well as virtually, and to know what is being done to address current deficiencies.

There are some states that do currently accept the availability of telehealth as one of the reasonable criteria for assessing network adequacy. The examples below show the range of whether telehealth is allowed to be included in network adequacy metrics, or as an acceptable means to address a deficiency.

> California: "*Plans governed by* [the California Department of Insurance] *may apply for a waiver for network adequacy requirements when (1) certain services are not available in a plan area, (2) a plan is unable to contract with a sufficient number of providers in an area, (3) a provider or facility leaves the network, or (4) a plan engages in an innovative network design that benefits enrollees. Similar to* [Department of Managed Health Care] *regulated plans, insurers may sell plans with waivers to enrollees without meeting network adequacy requirements, but administrators must provide alternative access for enrollees by locating nearby providers and assisting enrollees to access appropriate care in a timely manner. Plans may also comply by providing transportation to care or by using telehealth services*."[75]
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> Colorado: "*Describe any barriers that affect the* [Managed Care Entity's] *ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services*."[76]
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> Illinois: "*Insurers must file for review a description of the services to be offered through a network plan. The description shall include all of the following: ... (D) a description of how the use of telemedicine, telehealth, or mobile care services may be used to partially meet the network adequacy standards, if applicable*."

[75] Cal. Health & Safety Code § 1367(e)(2); and 10 CCR § 2240.7 (2016)

[76] From Colorado Dept of Health Care Policy & Financing's FY 2020–2021 Network Adequacy Quarterly Report Template, Table 1B (ACC RAE 1 FY2021 Network Adequacy Report Q1 January 2021.pdf)

And:

"*(f) The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements set under this Section*."[77]

Michigan: Evaluation Factors to determine network adequacy in Michigan's Department of Insurance and Financial Services (DIFS) Network Adequacy Guidance include: "*Telemedicine/Telehealth: DIFS requires issuer networks to include providers offering services by alternate means in addition to in-person visits*."[78]

At the federal level, beginning in plan year 2023, CMS will collect from issuers of QHPs sold through FFEs information on whether providers participating in their network offer telehealth services. This information will not be used for network adequacy evaluations for 2023 or made available to the public, but will inform future regulatory approaches. Issuers that do not already have data on whether their providers offer telehealth will be required to have this information prior to QHP certification.[79] As mentioned previously, CMS will not require wait time metrics compliance until plan year 2024. At that time, telehealth appointments can be included if they are offered by providers who also offer in-person appointments.[80]

Additionally, in the Medicare Advantage market, CMS demonstrated a proactive approach to telehealth early in the pandemic with its 2020 *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance*.[81] The guidance allowed a 10 percent credit towards the percentage of beneficiaries who must reside within the maximum time and distance standards if the health plan contracted with telehealth providers in the following specialties: Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/OB/GYN, Endocrinology, and Infectious Diseases.

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[77] Illinois' Public Acts, (Source: P.A. 102-144, eff. 1-1-22; 102-901, eff. 7-1-22.) ilga.gov/legislation/ilcs/documents/021501240K10.htm.

[78] Michigan Network Adequacy Guidance, www.michigan.gov/difs/forms/insurance, accessed 6/10/2022.

[79] Centers for Medicare and Medicaid Services. "*2023 Final Letter to Issuers in the Federally-facilitated Exchanges*," www.hhs.gov/guidance/.

[80] *Ibid.*

[81] CMS. "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance", www.hhs.gov/guidance/.

As the MIA reevaluated its proposed revisions to Maryland's 2017 network adequacy regulations in response to the Act, various approaches were considered for assessing how telehealth can support network adequacy efforts. After considering all the potential benefits and drawbacks of telehealth coverage, the MIA determined that it was critical for the network adequacy regulations to encourage and incentivize carriers to improve access to telehealth services, while also ensuring that enrollees continue to have access to in-person services as needed. Obtaining more comprehensive and accurate data regarding telehealth availability and usage was identified as another priority for the regulations. Due to the desire to incentivize telehealth access and data collection, the MIA rejected the approach taken by some other states, where telehealth is only considered in a waiver context if a carrier is otherwise unable to satisfy a network adequacy standard.

It was determined that the "placeholder" telehealth clause in the original November 2020 draft would have been almost as equally difficult to operationalize as the 2017 regulations due to the lack of specificity in how a carrier was to demonstrate that an offered telehealth appointment was "clinically appropriate, available, and accessible to an enrollee." The MIA, therefore, considered whether to identify particular medical specialties where telehealth is considered clinically appropriate, and whether to develop specific data benchmarks and standards for when and where telehealth is considered to be available and accessible to enrollees. It was determined, however, that sufficient data was lacking to draw firm conclusions on these issues for the Maryland market.

The MIA next looked closely at the idea of offering some type of telehealth credit for extending access in areas of deficiency. This approach, pioneered by Medicare Advantage, appeared to have merit, but it was determined that the Medicare Advantage model did not include sufficient consumer protections to address the needs of all Maryland enrollees. For example, the Medicare Advantage credit does not include guardrails to ensure that geographic areas most in need of particular provider types have the internet bandwidth capabilities necessary to access telehealth services. Additionally, the Medicare Advantage credit does not ensure that the network still includes providers with physical office locations reasonably close to the otherwise applicable travel distance standards to address situations where telehealth is not clinically appropriate or is not chosen by the patient. The MIA ultimately determined that a modified telehealth credit with additional documentation requirements, coupled with substantial telehealth data reporting requirements, was the most appropriate way to leverage telehealth to support network adequacy efforts.

On July 7, 2022, the MIA exposed an updated draft network adequacy regulation for public comment, with new telehealth provisions included in COMAR 31.10.44.08.[82] The proposal would allow carriers to request a telehealth credit, subject to approval by the MIA, for both the travel distance standards and the appointment wait time standards. The proposal would also require all carriers to report certain data on telehealth utilization, regardless of whether the carrier requests a telehealth credit.

The proposed travel distance credit, if awarded, increases the maximum number of miles permitted to the nearest provider in zip codes where the carrier offers telehealth, but fails the otherwise applicable travel standard. This approach does not eliminate the requirement that a carrier must provide access to an in-network provider with a physical office location within a reasonable distance, but it does relax the distance requirement slightly if the telehealth credit is granted. The credit would be limited to a maximum of 10% of enrollees for each provider type in each geographic area.

Furthermore, the carrier is required to provide documentation justifying to the MIA that telehealth services are clinically appropriate, available, and accessible in the geographic area and for the particular provider specialty where the credit is being claimed. The regulation specifies the types of documentation that will be considered by the MIA in making this determination, but does not establish specific benchmarks or thresholds for the credit to be granted, leaving the final determination at the discretion of the MIA.

Since telehealth can also potentially help with wait time delays, it was important to allow a credit for that standard as well. However, given the previously discussed complications with the measurement methodology for wait times in general, there are additional challenges in ensuring telehealth is available and accessible in situations where the credit is requested. For this reason, the proposed revision stipulates that the wait time credit is partially contingent on requiring carriers to explain how they assist individual consumers who are unable to obtain a timely appointment and for whom telehealth is not appropriate or accessible.

While the draft proposal will undergo further refinement before it is finalized, it is anticipated that the new approach to telehealth will incentivize carriers to invest in telehealth in order to receive the credit, while the associated documentation requirements will provide the MIA with the timely data it needs to monitor trends and the corresponding impacts on network adequacy. The 10% cap for any element awarded, and the fact that approval of the credit is at the discretion of the MIA, ensures that providing telehealth alone will not act as a substitute for maintaining a sufficient network of providers offering in-person care.

[82] See Appendix F for the complete July 7, 2022 draft regulation.

Conclusion and Recommendations

All four phases of the MIA's study of changes in access to and coverage of telehealth services clearly demonstrated a significant expansion of telehealth benefits since 2019. The recent inclusion of coverage for audio-only consultations by all carriers was the most significant change that was noted. Other changes were not uniform across carriers, but trends were still observed suggesting that benefits were being expanded to encompass more provider specialties, more forms of communication, and more modalities of telehealth than in the past. The study also provided evidence that cost-sharing innovations to incentivize the use of telehealth are becoming more common. Finally, accessibility to telehealth appears to be increasing as a result of carrier acceptance of all HIPAA-compliant non-proprietary platforms for the delivery of telehealth, carrier coverage of previously excluded audio-only visits, and the addition of telehealth-only providers to carrier networks to supplement the existing telehealth services rendered by in-network providers who offer telehealth in addition to in-person services. As demonstrated by the MIA's findings in the study, no evidence of any restrictions on the availability of in-person services was uncovered for Maryland health benefit plans. The national data did, however, expose one instance of an insurance product in another state that required enrollees to receive an initial telehealth consultation before being referred to in-person services.

The MIA's study of how telehealth can support efforts to ensure health care provider network sufficiency provided strong evidence that there are many ways that telehealth can accomplish this goal without sacrificing consumer access to in-person services. Telehealth has tremendous potential to improve access to care in a variety of situations (including where there are provider shortages, transportation or travel issues, and appointment delays), and from a variety of different perspectives (including expanding the population of qualified providers, extending hours of service, and triaging patients according to their needs). However, it is imperative to ensure that the technological infrastructure exists so that telehealth services are truly accessible to the consumers who wish to utilize them. At the same time, the study revealed that there has been little action taken to date in other states or by the federal government to proactively consider telehealth in the network adequacy context. The MIA's own experience with its current network adequacy regulations and the review of access plans filed over the last five years revealed significant challenges with existing regulatory processes that have actually stifled carrier investment in telehealth to an extent. Maryland has been a leader in the realm of network adequacy and telehealth in the past, and the "wait and see" approach being exercised by several other states does not seem prudent for Maryland based on what the MIA has already learned. The MIA has observed a clear need for regulations that will require additional telehealth data collection, reward carriers for investing in telehealth, and allow ongoing monitoring of the impact of telehealth on network adequacy.

Several issues were identified as a result of the study that may warrant consideration by the Maryland General Assembly. The complaint data compiled by the MIA, though limited, reflected strong consumer and provider preference for expansions in coverage for telehealth. Consumer and provider demand may drive market trends for the types of telehealth benefits offered by carriers, but absent statutory requirements, each carrier would have the ability to choose whether or not to offer certain telehealth services under their contracts, and choose what level of cost-sharing to apply to the services. For example, no carrier provided broad coverage for audio-only consultations prior to the pandemic, and the MIA received many complaints over denials of these services. As mentioned previously, the requirement for carriers to cover audio-only telephone conversations under § 15-139 of the Insurance Article is currently set to expire on June 30, 2023. Additionally, while carriers began offering preferential cost-sharing for telehealth services as a result of the public policy recommendations during the public health emergency, § 15-139 does not currently address the level of cost-sharing that may be applied to telehealth services. The legislature may wish to consider whether or not § 15-139 should be revised to make the audio-only coverage requirement permanent, and/or whether the statute should be revised to include more express requirements related to other modalities of telehealth, the specific types of provider specialties and services eligible for telehealth coverage, and cost-sharing levels for telehealth services versus comparable in-person services.

Furthermore, while the MIA found no evidence of restrictions on the availability of in-person services under Maryland health benefit plans, another potential policy consideration for the General Assembly is whether or not to follow the lead of certain other states in codifying more express prohibitions against telehealth-only and/or telehealth-first stipulations in insurance contracts. While the MIA is not aware of any products currently being sold in the country that solely provide coverage for telehealth services, the study did reveal that at least two national carriers are currently selling products in a limited number of other states that require the use of a telehealth-only provider as an initial gatekeeper to direct additional in-person care or virtual care. Current Maryland law expressly prohibits a carrier from excluding or denying coverage for a behavioral health care service provided on an in-person basis solely on the grounds that the service may also be provided through telehealth.[83] However, provisions requiring a service to be received via telehealth in order to be covered are not otherwise expressly prohibited under Maryland law. In evaluating whether legislation is appropriate or necessary in this area, a variety of factors would need to be considered, including market demands, product pricing impacts, a potential negative effect on product innovation, convenience for consumers, and overall patient/provider preferences related to telehealth (which may not be consistent among all consumers and providers).

[83] Insurance Article, § 15-139(c)(1)(iii), Annotated Code of Maryland.

Appendix J: MIA November 4, 2020 Title 31 Draft Regulation

Appendix A

November 4, 2020 Draft Regulations

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 44 Network Adequacy

Authority: Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Ambulatory infusion therapy center" means any location authorized to administer chemotherapy or infusion services on an outpatient basis.

[(2)] *(3)* – [(4)] *(5)* (text unchanged)

(6) "Drug and alcohol treatment program" means any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.

[(5)] *(7)* "Enrollee" means a person entitled to health care benefits from a carrier *under a policy or contract subject to Maryland law.*

[(6)] *(8)* "Essential community provider" means a provider that serves predominantly low-income or medically underserved individuals. "Essential community provider" includes:

(a) (text unchanged)

(b) Outpatient [behavioral] *mental* health and community based substance use disorder programs;[and]

(c) Any entity listed in 45 CFR §156.235(c); *and* [.]

(d) School-based health centers.

[(7)] *(9)* – [(12)] *(14)* (text unchanged)

(15) "Hospital-based physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(13)] *(16)* – [(14)] *(17) (text unchanged)*

[(15)] *(18)* "Network adequacy waiver [request]" means [a written request from a carrier to the Commissioner wherein the carrier seeks] the Commissioner's [approval to be relieved] *decision to relieve a carrier of the obligation to comply with* certain network adequacy standards in this chapter for 1 year.

(19) "On-call physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(16)] *(20)* – [(21] *(25)* (text unchanged)

(26) "School-based health center" means a community health resource described in Health-General Article, § 19-2101, Annotated Code of Maryland that is located within an elementary, middle, or high school and approved by the Maryland State Department of Education.

[(22)] *(27)* – [(23)] *(28)* (text unchanged)

[(24)] *(29)* "Telehealth" [means:

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a provider to deliver a health care service within the scope of practice of the provider at a location other than the location of the patient.

(b) "Telehealth" does not include:

(i) An audio-only telephone conversation between a provider and a patient;

(ii) An electronic mail message between a provider and a patient; or

(iii) A facsimile transmission between a provider and a patient.] *has the meaning stated in Insurance Article §15-139, Annotated Code of Maryland.*

[(25)] *(30)* – [(26)] *(31)* (text unchanged)

[(27)] *(32)* "Waiting time" means the time from the initial request for health care services by an enrollee or by the enrollee's treating provider to the earliest date offered for the appointment for services *with a provider possessing the appropriate skill and expertise to treat the condition.*

.03 Network Adequacy Standards.

A. Sufficiency Standards.

(1) A carrier shall develop and maintain a complete network of adult and pediatric primary car, mental and behavioral health, substance use disorder, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of covered benefits.

(2) A carrier shall clearly define and specify referral requirements to specialty and other providers.

(3) A carrier shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

(4) A carrier's written policies and procedures to monitor availability of services shall include how the carrier will monitor the availability of services for:

(a) Continuity of care;

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(b) Individuals with physical or mental disabilities, including physical access issues; and
(c) Individuals with limited English proficiency, including diverse cultural and ethnic backgrounds.
(5) A carrier shall ensure services are delivered in a culturally competent manner to all enrollees, including enrollees:
(a) With limited English proficiency;
(b) With diverse cultural and ethnic backgrounds; and
(c) Of all genders, sexual orientations, and gender identities.
(6) A carrier shall include in its annual plan under Regulation .04 of this chapter, by zip code, the number of providers by Board specialty, including but not limited to:
(a) The American Board of Medical Specialties;
(b) The American Board of Pharmacy Specialties;
(c) The American Board of Physical Therapy Specialties;
(d) The American Board of Professional Psychology;
(e) The Accreditation Board for Specialty Nursing Certification; and
(f) The American Academy of Nurse Practitioners Certification Board.
B. Monitoring Sufficiency Standards.
(1) A carrier shall monitor its provider network for compliance with this chapter on at least a monthly basis; and
(2) A carrier shall monitor out of network costs to members when network providers are not available and report this information on a form provided by the Administration on a quarterly basis.

[.03] .*04* Filing of Access Plan.
A. Using the instructions on the Maryland Insurance Administration's website *for submission method and* to determine rural, suburban, and urban zip code areas, each carrier subject to this chapter shall file an annual access plan with the Commissioner [through the System for Electronic Rate and Form Filing (SERFF)] on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.
B. (text unchanged)
C. Each annual access plan filed with the Commissioner shall include *the following information in the standardized format described on the Maryland Insurance Administration's website*:
(1) An executive summary in the form set forth in Regulation [.09] *.10* of this chapter;
(2) (text unchanged)
(3) The description required by Insurance Article, §15-112(c)(4)(iv) shall include:
(a) The number of primary care physicians, including pediatricians, family practitioners, and internists, who report to the carrier that they use any of the following languages in their practices:
(i) American Sign Language;
(ii) Spanish;
(iii) Korean;
(iv) Chinese (Mandarin or Cantonese);
(v) Tagalog; or
(vi) French;
(b) A description of outreach efforts to recruit and retain providers from diverse cultural or ethnic backgrounds;
(c) A copy of the most recent enrollees' language needs assessment made by or on behalf of the carrier, if one was made;
(d) A copy of the most recent demographic profile of the enrollee population made by or on behalf of the carrier, if one was made;
(e) A copy of any analysis or assessment made of provider network requirements based on an assessment of language needs or demographic profile of the enrollee population;
(f) A copy of any provider manual provisions that describe requirements for access to individuals with physical or mental disabilities; and
(g) Copies of policies and procedures documents designed to ensure that the provider network is sufficient to address the needs of both adult and child enrollees, including adults and children with:
(i) Limited English proficiency or illiteracy;
(ii) Diverse cultural or ethnic backgrounds;
(iii) Physical or mental disabilities; and
(iv) Serious, chronic, or complex health conditions.
[(3)] *(4)* Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations [.04] *(.05)* — [.06] *(.07)* of this chapter; [and]
(5) A description of the network access to hospital-based providers, which shall include:
(a) A list of all the hospitals included on the provider panel; and
(b) For each hospital included on the provider panel:
(i) The percentage of on-call physicians practicing in the hospital who are participating providers;
(ii) The percentage of hospital-based physicians practicing in the hospital who are participating providers;
(iii) The percentage of anesthesiologists practicing in the hospital who are participating providers;

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(iv) The percentage of radiologists practicing in the hospital who are participating providers; and
(v) A report of whether any non-physician providers, including laboratories or radiology facilities, within the hospital that routinely provide services to patients are not participating providers; and
[(4)] *(6)* (text unchanged)

[.04] .05 Travel Distance Standards.
A. Sufficiency Standards.
(1) Standard and Methodology
[(1)] *(a)* Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, [behavioral] *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area.
(b) The distances listed in §A(5) of this regulation shall be:
(i) [measured] *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence[.]*; and*
(ii) Calculated based on road travel distance.
(c) Except for those provider types excluded under §A(3) of this regulation, for each provider type and facility type included on the carrier's provider panel, the carrier shall:
(i) Map the practicing locations of every network provided within the geographic area served by the carrier's network or networks;
(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider location;
(iii) For each zip code identify the total number of enrollees residing in the zip code and the number of enrollees residing within an area where the applicable distance standard is not met;
(iv) For each zip code calculate the percentage of enrollees residing within an area where the applicable distance standard is met;
(v) For each of the urban, rural, and suburban areas identify the total number of enrollees residing in the geographic area;
(vi) For each of the urban, rural, and suburban areas identify the total number of enrollees residing within an area where the applicable distance standard is not met; and
(vii) For each of the urban, rural, and suburban areas identify the percentage of enrollees residing within an area where the applicable distance standard is met.
(d) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficient standards in this regulation:
(i) Geo-access maps for each provider type and facility type except for those excluded under §A(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standards is not met;
(ii) For zip codes whether a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees' access to care under the travel distance standards; and
(iii) For any facility types listed in §A(5) of this regulation the provider services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.
(e) A carrier shall report each number and percentage described in §A(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.
(2) – (3) (text unchanged)
(4) All other providers and facility types *included on the carrier's provider panel but* not listed in the chart in §A(5) of this regulation, *including physical therapists, nutritionists, and dietitians,* shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.
(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60
Cardiovascular Disease	10	20	60
Child Psychiatry	*10*	*25*	*60*

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Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
Geriatric Psychiatry	*10*	*25*	*60*
Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
Licensed Professional Counselor	*10*	*25*	*60*
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30
Physiatry, Rehabilitative Medicine	15	30	75
Physician Certified in Addiction Medicine	*10*	*25*	*60*
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician *(non-pediatric)*	5	10	30
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All Other licensed or certified providers under contract with a carrier not listed	15	40	90
Facility Type:			
Acute Inpatient Hospitals	10	30	60
Ambulatory Infusion Therapy Centers	*10*	*30*	*60*
Critical Care Services — Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Drug and Alcohol Treatment Program	*10*	*25*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60]
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Skilled Nursing Facilities	10	30	60
Substance Use Disorder Residential Treatment Facility	*10*	*25*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60

Replaced by 7-7-22 draft

[Other Behavioral Health/Substance Abuse Facilities	10	25	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	90

B. Group Model HMO Plans Sufficiency Standards.

(1) Standard and Methodology

[(1)] *(a)* Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care physicians, specialty providers, [behavioral] *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(5) of this regulation for each type geographic area.

(b) The distances listed in §B(5) of this regulation shall be:

(i)[measured] *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan[.]; *and*

(ii) Calculated based on road travel distance.

(c) Except for those provider types excluded §B(3) of this regulation, for each provider type and facility type included on the group model HMO's provider panel, the carrier shall:

(i) Map the practicing locations of every network provider within the geographic area served by the group model HMO's network or networks;

(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations;

(iii) For each zip code identify the total number of enrollees with a residence or place of employment in the zip code and the number of enrollees with a residence or a place of employment within an area where the applicable distance standard is not met;

(iv) For each zip code calculate the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met;

(v) For each of the urban, rural, and suburban areas identify the total number of enrollees with a residence or place of employment in the geographic area;

(vi) For each of the urban, rural, and suburban areas identify the number of enrollees with a residence or place of employment within an area where the applicable distance standard is not met; and

(vii) For each of the urban, rural, and suburban areas identify the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met.

(d) When calculating the number or percentage of enrollees with a place of employment within an area or zip code under §B(1)(c)(iii)-(viii) of this regulation, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO's health benefit plan from their place of employment.

(e) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §B(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standard is not met;

(ii) For zip codes where a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees' access to care under the travel distance standards; and

(iii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(f) A carrier shall report each number and percentage described in §B(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.

(2) – (3) (text unchanged)

(4) All other provider and facility types *included on the carrier's provider panel, but* not listed in the chart at §B(5) of this regulation, *including physical therapists, nutritionists, and dietitians,* shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60

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Cardiovascular Disease	15	25	60
Child Psychiatry	*15*	*30*	*75*
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Geriatric Psychiatry	*15*	*30*	*75*
Gynecology, OB/GYN	15	20	45
Gynecology Only	15	30	60
Licensed Clinical Social Worker	15	30	75
Licensed Professional Counselor	*15*	*30*	*75*
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45
Physiatry, Rehabilitative Medicine	15	30	75
Physician Certified in Addiction Medicine	*15*	*30*	*75*
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care Physician *(non-pediatric)*	15	20	45
Psychiatry	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
Facility Type:			
Acute Inpatient Hospitals	15	30	60
Ambulatory Infusion Therapy Center	*15*	*30*	*60*
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Drug and Alcohol Treatment Program	*15*	*30*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60]
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Skilled Nursing Facilities	15	30	60

Replaced by 7-7-22 draft

Substance Use Disorder Residential Treatment Facility	*15*	*30*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	15	30	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

C. Essential Community Providers.

(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include:

(a)[at] *At* least 30 percent of the available essential community providers *providing medical services* in each of the urban, rural, and suburban areas[.];

(b) At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and

(c) At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.

(2) Methodology for calculating essential community provider inclusion standard.

(a) Except as provided in §§C(2)(b) and (c) of this regulation, a carrier shall use the MHBE ECP Network Inclusion Calculation Methodology that is described in the Instructions on Meeting the Essential Community Provider Plan Certification Standard guidance provided by the Maryland Health Benefit Exchange, which is current as of the date three months prior to the due date of the annual access plan.

(b) The calculation described in §C(2)(a) of this regulation shall be performed separately for essential community providers providing medical services, mental health services, and substance use disorder services in each of the urban, rural, and suburban areas.

(c) If the Maryland Health Benefit Exchange changes the MHBE ECP Network Inclusion Calculation Methodology after the effective date of this regulation, a carrier may not use the revised methodology to calculate the essential community provider inclusion standard in §C(1) of this regulation unless the Commissioner has approved the revised methodology for this purpose.

[(2)] *(3)* – [(3)] *(4)* (text unchanged)

[.05] *.06* Appointment Waiting Time Standards.

A. Network capacity.

(1) Each carrier shall create and utilize written policies and procedures to monitor the availability of services.

(2) On a quarterly basis, each carrier shall make available to its members the median wait times to obtain the following appointments with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter as measured from the date of the initial request to the date of the earliest available appointment:

(a) Urgent care for medical services;
(b) Inpatient urgent care for mental health services;
(c)Inpatient urgent care for substance use disorder services;
(d) Outpatient urgent care for mental health services;
(e)Outpatient urgent care for substance use disorder services;
(f) Routine primary care;
(g) Preventive care/well visits;
(h) Non-urgent specialty care;
(i) Non-urgent mental health care; and
(j) Non-urgent substance use disorder care.

(3) To monitor availability of providers, a carrier shall:

(a) Ensure the accuracy of its provider directory;
(b) Utilize a survey tool with members;
(c) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available appointments; and
(d)Retain documentation of the efforts described in §A(3)(a) – (c) of this regulation.

(4) The survey toll described in §A(3)(b) of this regulation shall:

(a) Utilize a statistically valid method to ensure that survey respondents are selected in a random manner;

(b) Ask members to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; and

(c) Ensure a minimum sample size of responsive answers for each appointment type listed in §A(2) of this regulation that is equivalent to the lesser of:

(i) Ten present of claims received by the carrier for that appointment type in the same quarter of the preceding calendar year; or

(ii) One hundred answers.

(5) The minimum sample size for the random selection of provider offices described in §A(3)(c) of this regulation shall be equivalent to the lesser of:

Replaced by 7-7-22 draft

(a) Ten percent of the participate providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation; or

(b) One hundred provider offices.

(6) The median wait times described in §A(2) of this regulation shall be calculated by:

(a) Determining the median wait time based on the results of the member surveys described in §A(3)(b) of this regulation and multiplying that number by 0.25;

(b) Determining the median wait time based on the direct contacts with provider offices described in §A(3)(c) of this regulation and multiplying that number by 0.75; and

(c) Adding the results in §A(6)(a) and §A(6)(b) of this regulation.

[A.] *B.* Sufficiency Standards.

(1) On a quarterly basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the member surveys and the direct contacts with provider offices described in §A(3)(b)-(c) of this regulation.

[(1)] *(2)* Subject to the exceptions in [§B] *§§C and D* of this regulation, [each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel] *if a carrier's provider panel fails to meet the waiting time standards listed in §E of this regulation for at least 90% of appointments in each category, the carrier shall notify the Administration within 10 business days identifying the deficiency in the provider network and the efforts that have been taken or will be taken to correct the deficiency.*

[(2)] *(3)* When [it] *a telehealth appointment* is clinically appropriate, *available, and accessible to* [and] an enrollee [elects to utilize a telehealth appointment], a carrier may consider [that utilization] *the offer of that appointment* as a part of its meeting the standards listed in [§C] *§E* of this regulation.

[B.] *C.* Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or [behavioral] *mental* health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider's license, certification, or other authorization.

D. A visit scheduled in advance in accordance with §C of this regulation may be disregarded when determining compliance with the waiting time standards listed in §E of this regulation.

[C.] *E.* Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care *for medical services* [(including] medical, behavioral health, and substance use disorder services)]	72 hours
Inpatient urgent care for mental health services	*72 hours*
Inpatient urgent care for substance use disorder services	*72 hours*
Outpatient urgent care for mental health services	*72 hours*
Outpatient urgent care for substance use disorder services	*72 hours*
Routine primary care	15 calendar days
Preventive [visit] *care*/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent mental health care	*10 calendar days*
Non-urgent [behavioral health/]substance use disorder [services] *care*	10 calendar days

F. On a quarterly basis, each carrier shall forward to the Administration a list of complaints it receives relating to the unavailability of a provider.

[.06] .*07* Provider-to-Enrollee Ratio Standards.

A. (text unchanged)

B. The provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider for:

Replaced by 7-7-20 change

(1) – (3) (text unchanged)
(4) 2,000 enrollees for [behavioral] *mental* health care or services; and
(5) (text unchanged)

C. The ratios described in §B of this regulation shall be calculated based on:

(1) The number of enrollees covered under all health benefit plans issues by the carrier in Maryland that use that provider panel; and

(2) The number of providers in that provider panel with practicing locations:

(a) In Maryland; or

(b) Within the applicable maximum travel distance standard specified in Regulation .04 of this chapter outside the geographic boundaries of Maryland.

[.07] *.08 Network Adequacy* Waiver [Request] Standards.

A. [A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.] *If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05-.07 of this chapter, the carrier shall provide the following information to the Commissioner as part of the annual access plan:*

(1) A description of any network adequacy waiver previously granted by the Commissioner;

(2) An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with to satisfy each unmet standard;

(3) A description of the methodology used to calculate the estimated number of providers in §A(2);

(4) A list of physicians, other providers, or health care facilities related to each unmet standard and within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(5) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(6) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(7) Identification of all incentives the carrier offers to providers to join the network;

(8) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier failed to meet a standard;

(9) A detailed description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;

(10) A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard; and

(11) An attestation to the accuracy of the information provided in relation to each unmet standard.

B. The Commissioner may find good cause to grant [the] *a* network adequacy waiver [request] *of one or more of the standards specified in Regulations .05-.07 of this chapter*, if *the information provided by* the carrier *under §A of this regulation* demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) – (4) (text unchanged)

C. [A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

(1) A description of any waiver previously granted by the Commissioner;

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;

(6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and

(7) An attestation to the accuracy of the information contained in the network adequacy waiver request.] *The Commissioner shall post a list of all network adequacy waivers that are granted for each annual access plan on the Maryland Insurance Administration's website.*

[.08] *.09* Confidential Information in Access Plans.

A. Subject to §15-802 of the Insurance Article, Annotated Code of Maryland, the following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

(1) [Methodology] *Proprietary methodology* used to annually assess the carrier's performance in meeting the standards established under this chapter;

(2) [Methodology] *Proprietary methodology* used to annually measure timely access to health care services; and

(3) (text unchanged)

B. A carrier submitting an access plan or [a] *supplemental information required for the* network adequacy waiver [request] *standards* may submit a written request to the Commissioner that specific information included in the plan [or request] not be disclosed under the Public Information Act and shall:

(1) – (2) (text unchanged)

C. – D. (text unchanged)

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[.09] .*10* Network Adequacy Access Plan Executive Summary Form.

A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the *following* network sufficiency results for the health benefit plan service area [as follows] *in the standardized format described on the Maryland Insurance Administration's website*:

(1) Travel Distance Standards.

(a) For each provider type *and facility type* listed in Regulation [.04] *.05*, list the percentage of enrollees for which the carrier met the travel distance standards, in the following format:

	Urban Area	Suburban Area	Rural Area
Primary Care Provider			
Specialty Provider			

(b) All provider and facility types described in §§ A(4) and B(4) of Regulation .05 of this chapter and included on the carrier's provider panel shall be listed individually in the chart described in §A(1)(a) of this regulation with the corresponding data for that specific type of provider or facility.

[(b)] *(c)* – [(c)] *(d)* (text unchanged)

[(d)] *(e)* List the total number of essential community providers in the carrier's network *in each of the urban, rural, and suburban areas providing:*

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

[(e)] *(f)* List the total percentage of essential community providers available in the health benefit plan's service area that are participating providers *for each of the nine categories described in §A(1)(e) of this regulation.*

(g) List the total number and percentage of local health departments in the carrier's network providing:

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

(2) Appointment Waiting Time Standards.

(a) For each appointment type listed in Regulation [.05] *.06*, list the [percentage of enrollees for which the carrier met the appointment wait time standards] *calculated median wait time to obtain an appointment with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter*, in the following format:

Appointment Waiting Time Standard Results
Urgent care *for medical services* [— within 72 hours]
Inpatient urgent care for mental health services
Inpatient urgent care for substance use disorder services
Outpatient urgent care for mental health services
Outpatient urgent care for substance use disorder services
Routine primary care [— within 15 calendar days]
[Preventative Visit] *Preventive care*/Well Visit[— within 30 calendar days]
Non-urgent specialty care [— within 30 calendar days]
[Non-urgent ancillary services — within 30 calendar days]
Non-urgent [behavioral] *mental* health[/substance use disorder services — within 10 calendar days] *care*
Non-urgent substance use disorder care

(b) List the total [percentage] *number* of telehealth appointments counted as part of the appointment waiting time standard results *for each type of visit.*

(c) List the percentage of appointments counted as part of the appointment waiting time standard results for each type of visit that were telehealth appointments.

(3) Provider-to-Enrollee Ratio Standards.

(a) (text unchanged)

(b) For all other carriers, [list whether the percentage of provider-to-enrollee ratios meet the] *summarize the network performance for each* provider-to-enrollee ratio [standards] *standard* listed in Regulation [.06] *.07* of this chapter *by listing the calculated number of providers in the provider panel, rounded to the nearest whole number,* for each of the following categories *of enrollees*:

(i) – (iii) (text unchanged)

(iv) 2,000 enrollees for [behavioral] *mental* health care or service; and

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(v) (text unchanged)
B. (text unchanged)

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Appendix K: MIA Analysis of Form Filing Trends in Telehealth Coverage

Analysis of Form Filing Trends in Telehealth Coverage

Throughout this Appendix the term "telehealth" is used to describe virtual care services, except when distinguishing specific virtual benefits that are covered by a particular carrier. There were inconsistencies in the use of the terms "telemedicine" and "telehealth" between different carrier contracts, but the inconsistency did not equate with substantive variation in the coverage provided. Licensed carriers are identified by letter, and in some cases, by letter and numeral. The letter corresponds to a parent company. If a parent company has separately licensed subsidiary carriers (such as entities licensed as an HMO, nonprofit health service plan, or insurer), a numeral is included to differentiate between the affiliated carriers under the parent company.

Individual Non-Grandfathered Market

From 2019 to 2022, the individual non-grandfathered market in Maryland consisted of carriers A.1., A.2., B.1., and D.1. Carriers A.1., A.2. and B.1. were active in the market for all four years.

2019

In 2019, carriers A.1, A.2. and B.1. were in the individual non-grandfathered market. All three carriers' contracts included basic benefit descriptions and definitions of telehealth. In general, the descriptions appeared to be broad, and used the term "interactive" technology to describe the benefit. Carriers A.1 and A.2 specified in the certificate of coverage that there is no annual dollar maximum or annual visit limitation for this benefit.

Carriers A.1. and A.2. submitted amendments to their benefit contracts in 2019. These amendments did not contain any references to telehealth services, so the base contract that was being amended was reviewed. The older base contract that was approved for use in 2017 contained a telemedicine benefit description that was broad and contained coverage for "interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient." The description went on to state that telehealth services would be provided at a site other than the site where the provider is located. A similar definition was found in carrier B.1.'s filing and appeared to be in line with the definition of telehealth found in §15-139(a) of the Insurance Article at the time.

It is worth noting that while the 2019 amendments filed by carriers A.1. and A.2. did not make any revisions to the telehealth benefit in the base contract, the amendments did revise the base forms to add programs that focused on weight loss, behavioral health, substance use disorder, and complex care. The programs cover “coordination of care” via telephone.

The 2019 filings for carriers A.1., A.2. and B.1. contained exclusions for telephone calls and/or telephone consultations in the exclusions/limitations sections. The contracts for carriers A.1., A.2. (2017 base contracts) and B.1. excluded “audio-only telephone” and “electronic mail message, or facsimile” conversations. Carrier B.1. specifically excluded “telephone therapy” under the mental health and substance abuse benefit.

In regard to cost-sharing in 2019, carriers A.1. and A.2., simply stated that telehealth benefits were provided to the same extent as benefits provided for other services. As mentioned above, the certificate of coverage mentions that no annual dollar maximum or any other annual limitation would be applied to the telehealth benefits. Carrier B.1. covered telehealth by applying “no charge” or "no charge after deductible" in line with other services.

2020

In 2020, carriers A.1, A.2., and B.1. were in the individual non-grandfathered market. Carriers A.1., A.2 and B.1 did not amend or change their telehealth benefit descriptions or cost share amounts. However, A.1 and A.2. amended the “Care Support Program” in the 2017 base contracts to clarify that “Care Support Programs can include but are not limited to: telemedicine services”. B.1. mentioned telehealth under maternity services in the benefit description as well as the cost share in the schedule of benefits; however, the reference is only mentioned and not separated as having a different/separate cost share. Otherwise, the same as noted in 2019 applies.

2021

In 2021, carriers A.1, A.2., B.1. and D.1. were in the individual non-grandfathered market. Carriers A.1. and A.2. amended the definition of telehealth to include “delivery of mental health care services to a patient in their home setting,” which corresponded with a legislative change to the telehealth definition found in §15-139(a) of the Insurance Article. Carrier B.1. also added references to the home setting. No other changes were made to these filings.

Carrier D.1. covered telehealth as a standard benefit and included the delivery of mental health care services in a person’s home setting. Similar to the other carriers, D.1. excluded audio-only telephone, facsimile, and electronic mail communication. However,

D.1. made a distinct reference to exclude other types of communication such as “texting and instant messaging.” D.1. specifically excludes “telephone therapy” under the mental health and substance abuse benefit similar to B.1. above.

All carriers continued to/exclude telephone consultations in their respective exclusions/limitations sections.

Carriers A.1., A.2., and B.1. maintained the same cost-shares for their telehealth as 2020. D.1. applied “The first 3 telehealth visits per covered person per calendar year will be provided at no out-of-pocket cost to you. Additional telehealth visits are subject to any applicable copayment amount, deductible amount, and coinsurance percentage” for the telehealth benefit. There were other benefits that had three visits with no out of pocket costs. This was more generous compared to other benefits.

2022

In 2022, there were several changes to the telehealth benefit for all of the carriers.
Carriers A.1., A.2., B.1, and D.1. revised their telehealth benefits to allow for coverage of audio-only conversations. A.1. and A.2. amended the definition of telehealth in the 2017 base contract, which included changes to the blanket exclusion for audio-only telephone calls now being covered “only when required by law.” A.1. and A.2. moreover, amended the definition to include counseling and treatment for substance use disorders and mental health conditions. Furthermore, A.1., A.2., and B.1. continued to include reference to “the delivery of mental health care services to a patient in their home setting” within the definitions.

Carrier D.1. included two different benefits in their plans that were titled “Virtual Visits” and “Telehealth.” When questioned about the distinction, the carrier explained that “Telehealth is for providers with a traditional office space (i.e., primary care physicians, specialists) for a remote visit; virtual care is with a vendor that we contract with to have virtual services. An insured cannot have an in-person visit with a virtual care provider whereas you can have an in-person visit with a telehealth provider”.

A.1., A.2., and D.1. removed the exclusion related to telephone consultations from the exclusions and limitations sections. D.1 no longer excluded “telephone therapy” under the mental health and substance abuse benefit. Carrier B.1. continued to exclude telephone consultations within the exclusion/limitation and “telephone therapy” under the mental health substance abuse benefit.

2023

Carriers A.1., A.2. B.1. and D.1. filed forms to be used in the market for 2023. These filings were received and approved in 2022. Carriers A.1, A.2., B.1., and D.1.’s filings did not include any changes to the telehealth cost-share. Carrier A.1. did not include any

changes to the telehealth benefit/definition or the cost share. A.2 and B.1 revised the definition to remove reference to the member's home setting. B.1. no longer includes the "telephone therapy" exclusion in the mental health and substance abuse benefit. D.1. only changed the definition to include "audio-only" telephone conversations.

Carrier D.1. continues to separate "Virtual" services from telehealth services. When questioned about the difference between the two services they explained that virtual visits were services that
are covered services provided by a Network Provider that a member has the option of seeing in-person, instead is choosing to engage with in a remote setting (such as, home/workplace). Additionally, virtual visits required the member to see designated virtual providers, instead of any network provider, while the member was permitted to see any network provider to receive telemedicine services.

Carrier D.1. also included a "Virtual" gatekeeper plan design (Virtual First) that initially seemed to require members to select a virtual primary care physician that would act as a gatekeeper to other network providers. In response, to MIA inquiries during the form review process, the carrier explained the member does not have to use a virtual PCP ("vPCP"), that they can choose a non-virtual primary care provider depending on their preference. They further explain "For the Virtual First plans, members will be assigned the Designated Virtual Network Provider as their main avenue for receiving primary care and may access any vPCP who is affiliated with that Designated Virtual Network Provider and operating on its platform. To the extent a member prefers to receive primary care in an in-person setting, they retain the right to change their PCP assignment to any other Network PCP." In regard to how virtual primary care services are covered, D.1. explained it is dependent on who is delivering the care. They stated "Virtual primary care services will fall under the Telehealth benefit when delivered by a Network provider; alternatively, they will fall under the Virtual Care Services benefit when delivered by a vPCP operating on the Designated Virtual Network Provider's platform."

Small Group Non-Grandfathered Market

From 2019 to 2022, the small group non-grandfathered market in Maryland consisted of carriers A.1., A.2., B.1., C.1., C.2, D.1., and D.2. These carriers were active in the market for all four years.

2019

In 2019, carriers B.1., B.2., C.1., C.2., and D.2. all had what could be characterized as basic benefit descriptions and definitions of telehealth. In general, the descriptions appeared to be broad, except carriers C.1. and C.2. made specific references to coverage of physician services, specialists, and behavioral health providers as services that were subject to telehealth options. C.1. and

C.2. also included coverage of “two-way audiovisual teleconferencing, telephone calls, and any other method required by state law” that was not specified in the other carriers’ descriptions. C.1. and C.2. submitted amendments to their benefit contracts in 2019, however, these amendments did not revise the telehealth benefit description (base contracts approved for use in 2018). In order to receive coverage for telehealth, the member was required to use a provider that was contracted to provide telehealth services.

Carriers A.1. and A.2. submitted amendments to their benefit contracts in 2019. These amendments did not contain any references to telehealth services, so the base contracts that were being amended were reviewed. The base contract that was approved for use in 2017 contained a telehealth benefit description that was broad and contained coverage for “interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient.” The description went on to state that telehealth services would be provided at a site other than the site where the provider is located. A similar definition was found in carrier B.1.’s filing and appeared to be in line with the definition of telehealth found in §15-139(a) of the Insurance Article at this time. Carriers A.1 and A.2 specified in the certificate that there is no annual dollar maximum or annual visit limitation for this benefit. Carriers A.1., A.2. (2017 base contracts), B.1., and D.2.’s contracts excluded “audio-only telephone” and “electronic mail message, or facsimile” conversations. Carrier B.1., D.1., and D.2. specially excluded “telephone therapy” under the mental health and substance abuse benefit.

Carriers C.1. and C.2. contained separate cost-share breaks for telehealth specialists and physicians from in person office visits. The telehealth benefit for mental health and substance use disorder services was nested within the office visit benefit, and no distinction was made in the cost-share between telehealth and in person services. It is important to note that these cost shares were similar to the cost shares applied to other similar services.

Carriers D.1. included a “virtual visits” benefit but no telehealth benefits were found. The filing cover letter did not include any forms that mentioned the telehealth benefit either. This may have been an oversight since D.2. included the benefits. D.2. included two different benefits in their plans that were referred to as “virtual visits” and “telemedicine.” The carrier was not asked to explain the distinction between these two similar benefits in this filing during the form review process.

In regard to cost-sharing, with the exception of carriers C.1. and C.2., carriers applied cost sharing to the same extent as other similar services. Carriers A.1. and A.2., simply stated that telehealth benefits were provided to the same extent as benefits provided for other services. As mentioned above, the certificate of coverage mentions that no annual dollar maximum or any other annual limitation would be applied to the telehealth benefits. B.1. covered telehealth by applying “no charge” or "no charge after deductible" in line with other services. Carriers C.1. and C.2. applied separate cost-share breaks for telehealth specialists and

physicians from in person office visits. The telehealth benefit for mental health and substance use disorder services was nested within the office visit benefit, and no distinction was made in the cost-share for those benefits between telehealth and in person services. However, C.2. had a separate cost-share break for “telemedicine cognitive behavioral therapy consultations” from the other mental health and substance use disorder services. It is important to note that these cost shares were similar to the cost shares applied to other similar services. The telemedicine benefit in D.2. was set up to cover telemedicine based on type and place of services.

In regard to additional programs or benefits that promoted telehealth services, carriers A.1. and A.2. contained amendments that revised the base forms to add programs that focused on weight loss, behavioral health, substance use disorder, and complex care. The program specifically covered coaching and counseling sessions via telephone with cost-shared waived in most circumstances for the services. There were time limits placed on how long the member could participate in some of the programs with the cost-share waived, and the cost-share was not waived for charges such as prescription drugs or facility charges. In the case of high deductible health plans, the deductible would not be waived for services not considered to be preventive services

All carriers specifically excluded telephone consultations.

2020

Carriers A.1. and A.2. filed amendments that did not contain any changes to the telehealth benefit or cost-share. The amendments added a support program for individuals with certain conditions or complex health care needs to the base contracts that included telemedicine services within the program. These services were subject to the same deductible, copayments, and coinsurance as stated in the schedules of benefits. Carriers B.1. and D.2. did not make changes to their telehealth definitions, benefits, cost shares or exclusions.

Carrier C.1. did not make changes to their benefit description or the cost shares. C.2 revised its telehealth definition to include a more robust definition by adding the reference to mental health services. C.2. also did not make changes to the cost share benefit.

Carrier D.1. included a “virtual visits” benefit but no telehealth benefits were found. The filing cover letter did not include any forms that mentioned the telehealth benefit either. This may have been an oversight since D.2. included the benefits. D.2. included two different benefits in their plans that were referred to as “virtual visits” and “telemedicine.” The carrier was not asked to explain the distinction between these two similar benefits in this filing during the form review process

Carriers B.1., D.1., and D.2. continued to exclude “telephone therapy” under the mental health and substance abuse benefit. All carriers continued to specifically exclude telephone consultations.

2021

In the 2021 plans, all of the carriers revised their telehealth definitions, but they were not uniformly revised. Carriers A.1., A.2., B.1., C.1., C.2., and D.2. added references to coverage of mental health services in the patient’s home setting, which corresponded with a legislative change to the telehealth definition found in §15-139(a) of the Insurance Article.

D.1. included telehealth and virtual services benefits. The telehealth benefit description was in line with the statute and included reference to the member’s home setting. D.1. applied similar cost share as other services.

Carriers A.1., A.2., B.1., C.1. C.2. and D.2. maintained the same cost-shares as the previous years. These carriers maintained the same exclusions as noted above.

2022

In 2022, there were more changes to the telehealth benefit for all of the carriers. The changes included changes to the blanket exclusion for audio-only telephone calls. Carriers A.1, A.2, B.1., C.1., C.2., D.1., and D.2. revised their telehealth benefits to allow for coverage of audio-only conversations when they resulted in a billable service. Carrier B.1., C.1, C.2., D.1., and D.2. removed the reference to the member’s home setting from the definition.

Carriers C.1. and C.2. changed the requirement for using a contracted provider for telehealth services. C.1. and C.2. maintained the same cost share as the previous year. Carrier C.2. revised the benefit description to include out of network telehealth coverage which the carrier asserted “is now standardly included in all [carrier] medical plans, whether or not mandated by state law.” C.1. and C.2. also added specific exclusions related to telehealth coverage excluding “Audio-only phone call except as required by state law, Email and Fax”. C.1. and C.2. maintained the same cost-sharing structures as the previous year.

Carriers D.1. and D.2. revised their benefits section to remove the virtual visits benefit and included all telemedicine/virtual visits under one telehealth benefit. They also changed their cost share structure by offering their cost-shares so that a member would be able to receive a more beneficial cost-share if the member used a designated virtual provider for telehealth services. D.2. filed

a rider that provided additional telehealth benefits to members with co-occurring behavioral and medical conditions. The services include therapist and coaching sessions for an eight to ten-week period. These services are covered at no copayment, coinsurance, nor deductible, except for non-preventive services in high deductible health plans.

With the exception of B.1., all carriers removed the exclusions for telephone charges from their exclusions/limitations sections. B.1. continued to exclude telephone therapy in the mental health and substance abuse benefit.

2023

The 2023 filings were received and approved in 2022. There were notable changes to the telehealth benefit made in all filings.

Carriers A.1. and A.2. submitted new description of covered services forms which include revised definitions of telehealth that removed reference to a member's home setting. These carriers also include a virtual program called the "Virtual Connect" program. This program was filed as variable and included a bracketed age limit of "[2-19]". When asked how the virtual program differs from the telehealth benefit, the carrier explained that "benefits for charges related to coverage of telemedicine are provided to the same extent as benefits provided for similar treatment of preventive services or other illnesses. Benefits under the Virtual Connect Program are provided with no cost-sharing for the member, with the exception of federally qualified HSA plans, for which the Virtual Connect Program non-preventive services are subject to the deductible".

Carrier B.1. revised the definition to match closely with the statue. B.1. removed the "telephone therapy" exclusion from the mental health and substance abuse benefit and also removed the exclusion for "telephone consultations" from the exclusions/limitations section.

C.1. and C.2. removed the reference to "two-way" interactive conversations and added a broader definition. C.1. and C.2. added another cost share break to the Schedules under "Walk in clinic visits." These benefits are in line with other similar services. C.1. and C.2. added new exclusions for "telemedicine kiosk and Electronic vital signs monitoring or exchanges."

Carriers D.1. and D.2. did not change their benefit description or the cost share structure compared to the previous year. They tiered their cost-share structure so that a member would be able to receive a more beneficial cost-share if the member used a designated virtual provider for telehealth services. Carriers D.1. and D.2 included riders that provided a debit card containing money to be used for certain medical expenses, including services that are provided by a designated virtual provider. D.2. no

longer included the rider that provided additional telehealth benefits to members with co-occurring behavioral and medical conditions.

Student Health Plan Market

From 2019 to 2022, the student health market in Maryland consisted of carriers A.1., A.2., C.2 and D.2, E., F., and G. With the exception of carrier E and G., these carriers were active in the market for all four years.

2018/2019

In 2018/2019, carriers A.1., A.2., C.2, D.2., E, and F were in the student health market. All had what could be characterized as basic benefit descriptions and definitions of telehealth. However, unlike other carriers, carrier E specifically mentioned coverage of counseling services for mental health and substance use within the telehealth benefit. In general, the descriptions appeared to be broad, except carrier C.2. required use of a provider that is contracted to provide telemedicine services and also made specific references to coverage of physician services, specialists, and behavioral health providers as services that were subject to telehealth options. C.2. also included coverage of “two-way audiovisual teleconferencing, telephone calls, and any other method required by state law” that was not specified in the other carriers’ descriptions. Carrier C.2. did not state any specific exclusions under this benefit.

Carrier C.2. submitted several different school specific schedules of benefits. Generally, the plans were tiered: “Select care coverage” (care received from select care providers with lower cost-sharing), in-network coverage (in network providers) and out-of-network coverage. C.2. generally separated cost-share breaks for telehealth into three main benefits: physician’s services, mental health services, and substance abuse services. Some schedules included the telehealth benefit under “consultant services.” It is important to note that these cost shares were similar to the cost shares applied to other similar services.

Carrier F. amended a base contract (approved for use in 2015) to remove the exclusion for “telephone consultations.”

Carriers A.1. A.2., D.2., E., and F. excluded “audio-only,” electronic mail message, or facsimile conversations. Carrier A.1., A.2., and F. specifically excluded “telephone therapy” under the mental health and substance abuse benefit.

All carriers, with the exception of E. and F., specifically excluded “telephone consultations” within the exclusions/limitations section. E. excluded telephone calls within the “Travel Expenses” benefit.

2019/2020

Carriers A.1, A.2., C.2, D.2., F, and G were in the 2019/2020 student health market. A.1., A.2, and F did not make changes to their telehealth definitions, benefits, cost shares or exclusions.

Carrier C.2. did not make changes to their benefit description or the cost shares. C.2. revised its telehealth definition to include "other telecommunications or electronic technology ". The cost sharing structure did not show a separate telehealth service break for consultant services.

Carrier D. 2. did not include any telehealth related information in its filing for this year.

Carrier G included a standard benefit description of telehealth which specified coverage of counseling services for mental health and substance use within the telehealth benefit that mental health. Similar to carriers A.1. A.2., and F, carrier G excluded "audio-only", electronic mail message, or facsimile conversations. G excluded "telephone calls" within the "Travel Expenses" benefit. The cost share structure for G was tiered and telehealth was covered to the same extent as other similar services.

2020/2021

Carriers A.1, A.2., C.2, D.2., and G were in the 2020/2021 student health market. A.1., A.2, and G did not make changes to their telehealth definitions, benefits, cost shares or exclusions. Carrier D.2. included the same benefit, cost sharing structure, and definition as they did in year 2019, as stated above.

Carrier C.2. changed the benefit description and the definition. C.2. did not include a specific statement requiring a member to use a contracted provider for this benefit. Instead, the contract stated the benefit was the "use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a covered service within the scope of their practice at a location other than your location…" C.2. also included the delivery of mental health care in the member's home setting. C.2. applied the same cost sharing structure as they did in year 2020, as stated above.

2021/2022

Carriers A.2., C.2, D.2., and G were in the 2021/2022 student health market.

A.2. amended the base contract (approved to be used 2017/2018 academic year), by revising the definition. The definition included the delivery of mental health care services to a patient in their home setting. Furthermore, A.2. included the statement “A decision by [carrier] not to provide coverage for telemedicine in accordance with this amendment constitutes an Adverse Decision, if the decision is based on a finding that telemedicine is not Medically Necessary, appropriate or efficient.” Furthermore A.2. removed the “telephone therapy” exclusion from the mental health and substance use benefit. The exclusion for “telephone consultations" from the exclusions/limitation section was still present. The cost sharing structure continued to be provided to the same extent for other similar services.

C.2. revised the telehealth benefit by including the requirement to use a contracted provider for telehealth services. The definition and the cost sharing structure remained the same as above, however, there was a specific telehealth services break included within the consultant services benefit, similar to the 2019 cost sharing structure.

D.2. and G only revised the definition to include the delivery of mental health services to a patient in their home setting at the home setting. D.2. did not mention telehealth in the variable schedule of benefits submitted in the filing.

2022/2023

Carriers A.2., C.2, D.2., and G submitted filings for the 2022/2023 student health market. All carriers removed the reference to the patient's home setting from their definition and included “audio only” telephone conversations in the definition and benefit description. Furthermore, charges related to telephone consultations are removed from A. and C.2.

Carriers A.2. and G continued to exclude “electronic mail message or facsimile transmission” from the benefit.

C.2. revised the definition by including audio-only conversations and the time frame of July 1, 2021 to June 30, 2023 for how long the audio-only conversations will be permitted to be covered under telehealth. Furthermore, the benefit description was revised to specify the exclusions “Audio-only phone call except as described in the above paragraph, email and fax” for this benefit. The cost sharing structure did not change in comparison to the previous year.

The variable schedule of benefits submitting under carrier D.2.’s filing did not contain a telehealth services break.

The cost sharing structures for G were comparable to other similar services. The exclusion for “telephone calls” within the “Travel Expenses” benefit remained.

Large Group Market

From 2019 to 2022, the large group market in Maryland consisted of carriers A.1., A.2., B.1., B.2., C.1., C.2., D.1., D.2, and K. These carriers were active in the market for all four years.

2019

In 2019, carriers B.1., B.2., C.1., C.2., and K. all had what could be characterized as basic benefit descriptions and definitions of telehealth. In general, the descriptions appeared to be broad, except carriers C.1. and C.2. made specific references to coverage of primary care physicians (PCPs), specialists, and behavioral health providers as services that were subject to telehealth options. C.1. and C.2. also included coverage of “two-way audiovisual teleconferencing, telephone calls, and any other method required by state law” that was not specified in the other carriers’ descriptions.

Carriers A.1. and A.2. submitted amendments to their benefit contracts in 2019. These amendments did not contain any references to telehealth services, so the base contracts that were being amended were reviewed. Two separate base contracts were identified that were used by different groups for particular plan options. The older base contract that was approved for use in 2008 did not contain any reference to coverage of telehealth services. The base contract that was approved for use in 2016 contained a telehealth benefit description that was broad and contained coverage for “interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient.” The description went on to state that telehealth services would be provided at a site other than the site where the provider is located. This same definition was found in carriers B.1., B.2., and K.’s filings, and appeared to be in line with the definition of telehealth found in §15-139(a) of the Insurance Article at the time of the amendment.

Carriers D.1. and D.2. included two different benefits in their plans that were referred to as “virtual visits” and “telemedicine.” When questioned about the distinction, the carriers explained that telemedicine included services that were provided when the member was at a location that was determined to be at an “Originating Site” as defined by CMS (inpatient/outpatient hospitals, provider’s office, rural health clinics, and skilled nursing facilities). The carriers contended that virtual visits were services that were above and beyond the telehealth law requirements that included services that were rendered when the member was not at an Originating

Site, such as the home or workplace. Additionally, virtual visits required the member to see designated virtual providers, instead of any network provider, while the member was permitted to see any network provider to receive telemedicine services.

The 2019 filings for carriers B.1., B.2., D.1., and D.2. also contained exclusions for telephone calls and/or telephone consultations. In the case of carriers C.1. and C.2., the telehealth definition stated telephone calls were included within the telehealth benefit. Furthermore, carriers A.1. and A.2. had references to telephone consultations in their benefit programs, and had a general exclusion in the 2016 base contract that stated telehealth did not include audio-only telephone. These two carriers also had an exclusion for telephone consultations, except as described in the telehealth benefit. The 2008 base contract for carriers A.1. and A.2. contained an exclusion for telephone consultations, without any exceptions for telehealth.

The exclusions listed within the telehealth benefit for all of the carriers excluded email and facsimile transmissions. Carriers C.1. and C.2. had exclusions that did not permit coverage for services not provided through “interactive audio, video or other telecommunications or electronic technology.” C.1. also excluded electronic vital sign monitoring, services when the member was not present at the same time as the provider, and services from providers that were not contracted as telehealth providers.

Similarities and differences between the carrier filings in 2019 were also noted related to cost-sharing for telehealth benefits. It must be noted that large group filings submitted in Maryland are allowed to contain variable cost-share options. Therefore, in some cases, it was not clear what the cost-share for telehealth was for each plan design, unless there was language in the contract or explanation of variability that specified how telehealth would be covered. In the case of carriers A.1. and A.2., there was language in the 2016 base contract that specified telehealth benefits were provided to the same extent as benefits provided for other services. The contract also stated that no annual dollar maximum or any other annual limitation would be applied to the telehealth benefits. Carriers B.1. and B.2. both had variable cost-share options in their schedules of benefits for telehealth, but carrier B.2. had a statement in the benefits section assuring that telehealth benefits would be paid to the same extent as physician office visits.

Carriers C.1. and C.2. contained separate cost-share breaks for telehealth specialists and PCP visits from in person office visits. The telehealth benefit for mental health and substance use disorder services was nested within the office visit benefit, and no distinction was made in the cost-share for those benefits between telehealth and in person services. However, C.2. had a separate cost-share break for “telemedicine cognitive behavioral therapy consultations” from the other mental health and substance use disorder services. C.2. also included variable options to place a dollar maximum on telehealth services that were not placed on office in person visits.

Carriers D.1. and D.2. had separate cost share breaks for virtual visits and telemedicine. The virtual visit contained variable copayment, coinsurance, and no cost-sharing options, while the telehealth benefit in D.1. contained coinsurance and no cost-share options. The telemedicine benefit in D.2. was set up to cover telemedicine based on type and place of services. The provision also stated that if a benefit had an amount or duration limit placed on it, those limits would not be applied when the service was provided via telehealth.

In the case of carrier K., telehealth services were identified as subject to the same cost-share as other similar types of services. There was a separate optional cost-share break for behavioral telehealth consultations that would be pulled out separately from behavioral services if they were covered at a lower cost-share.

In regard to additional programs or benefits that promoted telehealth services, carriers A.1. and A.2. contained amendments that revise the base forms to add programs that focused on weight loss, behavioral health, substance use disorder, and complex care. The program specifically covered coaching and counseling sessions via telephone with cost-shared waived in most circumstances for the services. There were time limits placed on how long the member could participate in some of the programs with the cost-sharing waived, and cost-sharing was not waived for charges such as prescription drugs or facility charges. In the case of high deductible health plans, the deductible would not be waived for services not considered to be preventive services

Carriers D.1. and D.2. also contained riders in the 2019 filings that provided a program for individuals 18 or older who were at risk from “obesity-related diseases” that involved virtual obesity counseling, coaching, and other online resources. This program was covered with no copayments, coinsurance, or deductibles.

2020

In the 2020 filings, the telemedicine benefit was amended for carriers C.1. and C.2. by revising the definitions slightly to include a reference to “telephone calls” in brackets, indicating that coverage for telephone calls would be included or excluded based on plan design. C.2 revised its telehealth definition to include a reference to coverage of mental health services in a patient’s home setting. Telephone calls were also added to the list of exclusions, and C.1. added an exclusion for “telemedicine kiosks.” There were still variable options to cover telehealth for cognitive therapy at a separate cost-share. For C.1., the schedules of benefits contained variable options to include telehealth mental health and substance use disorder office visits at a same or different cost-share from in person mental health and substance use disorder office visits. In the case of C.2., telehealth for mental health and substance use disorder was nested within the same cost-share as mental health and substance use disorder office visits. The

physician office visits had options to include coverage for telehealth to the same extent as or different from in person physician office visits.

Carriers A.1. and A.2. filed amendments that did not contain any changes to the telehealth benefit or cost-share. The amendments added a support program for individuals with certain conditions or complex health care needs to the base contracts that included telemedicine services within the program. These services were subject to the same deductible, copayments, and coinsurance as stated in the schedules of benefits.

In 2020, carriers B.1. and B.2. did not make changes to their telehealth definitions, benefits, or exclusions. Carrier B.2. revised the cost-share statement to say that telehealth would be covered at the same deductible, copayment, and/or coinsurance for physician office visits “except maternity related ACA preventive care.” Prior to 2020, carrier B.2. did not make a distinction for telehealth maternity services from other telehealth services.

Carriers D.1. and D.2. maintained their separate virtual visits and telemedicine benefits, along with the same exclusions. D.1. made a slight change to the cost-sharing for telemedicine benefits to include the cost-share based on the type of service to align with the same cost-share applied to telemedicine in the 2019 D.2. filing. Additionally, D.1. added a reference to “consultation and treatment of mental health care, substance-related and addictive disorders” to the definition. Carriers D.1. and D.2. revised their virtual visit description to include an option for “audio only” to be included as part of the coverage. Furthermore, the rider that covered virtual coaching, counseling, and on line services related to morbid obesity was revised to lower the participation age from 18 and older to 13 and older.

Carrier K revised its telehealth definition to make reference to counseling for substance use disorders. Later in 2020, the benefit was revised again to add two benefits “dedicated virtual providers” and “virtual physician services” to the benefit section. These benefits were bracketed to be included or excluded and the difference between the benefits was that dedicated virtual providers required the use of a designated provider for the services. The virtual physician services did not include the same stipulation, but it also had a bracketed option to exclude telephone services that was not found in the dedicated virtual providers benefit. An explanation of variability that addressed when these two benefits would be included or excluded in the contract was not located, aside from a general explanation that benefits were bracketed to be included or omitted based on plan design. The schedules of benefits continued to maintain that telehealth was covered based on type of service, and there were bracketed options for virtual care to be covered to the same extent or different from mental health and substance use disorder office visits and physician office visits.

2021

In the 2021 plans, all of the large group carriers, except D.2 and C.2., revised their telehealth definitions and/or benefits, but they were not uniformly revised. Carriers A.1., A.2., B.1., B.2. and C.1, added references to coverage of mental health services in the patient's home setting, which corresponded with a legislative change to the telehealth definition found in §15-139(a) of the Insurance Article. Furthermore, carriers A.1. and A.2. included amendments that added the telehealth benefits to the 2008 base contracts that did not previously contain any reference to telehealth. Carrier K. included references to counseling for substance use disorders within the dedicated virtual providers and virtual physician services benefits, but did not include the reference to mental health services in a patient's home setting. Carrier C.2. had previously revised its definition in 2020 to add the reference to mental health services.

Carriers A.1., A.2., B.1., D.1., D.2., and K maintained the same cost-shares for their telehealth and virtual benefits as were included in 2020. Carriers C.1. and C.2. created new cost-share options in their schedules of benefits to provide 100% coverage for certain benefits up to a certain dollar limit. Telehealth was listed as a service that may be part of this cost-share option. These two carriers also maintained a variable benefit option to apply the same or different cost-share to telehealth cognitive therapy compared to mental health and substance use disorder office visits. Carrier C.1 revised its physician services section to establish separate cost-share options for telehealth PCP and specialist from in person PCP and specialist office visits. Carrier C.2 maintained its bracketed options to cover telehealth office at the same as or different cost-share from in person physician services.

In the case of B.2, the cost-share structure in the schedules of benefits was revised to allow for separate cost-share breaks for maternity service provided through telehealth as well as an option to include separate cost-sharing for physical therapy, speech therapy, and occupational therapy through telehealth than from other telehealth services.

2022

In 2022, there were more changes to the telehealth benefit for all of the carriers. The changes included revisions to the blanket exclusion for audio-only telephone calls. Carriers B.1., B.2., C.1., C.2., D.1., and D.2. revised their telehealth benefits to allow for coverage of audio-only conversations that resulted in a billable service. Carriers C.1. and C.2. included the time frame of July 1, 2021 to June 30, 2023 for how long the audio-only conversations would be permitted to be covered under telehealth. In 2022, Carriers A.1. and A.2. revised their benefit to cover all audio-only telephone conversations without any stipulations. Carrier K. maintained an exclusion for audio-only telephone services and there remained a variable option to include telephone calls as part of the dedicated virtual providers and virtual physician services benefits.

There were some notable changes to C.1. and C.2.'s cost-sharing structures and options related to telehealth. In the schedules of benefits, there were more options included for covering telehealth at the same or different cost-share from other services. The explanations of variability for these options show telehealth to be covered the same as or more beneficial than in person services of the same type. Carriers C.1. and C.2. also added a new optional benefit specific to telehealth services for telehealth specific providers. The contracts removed the previous requirement for telehealth services to be performed by a provider who was contracted with the carriers to provide telehealth services, and appeared to split these contracted providers out into a separate, optional service. These services would be covered the same as or lower than in person visits, but would not be covered at a cost-share that is lower than telehealth services provided by a "brick and mortar" provider.

Furthermore, an optional walk-in clinic visit benefit was amended to include the option for telehealth services under the benefit. The cost-share for telehealth under walk-in clinic was noted as the same as or lower than in person, but never lower than telehealth services provided by "brick and mortar" providers. C.2. also added visit and dollar limitations for telehealth services. The dollar limitation was in the 2019 plans, but was removed for 2020 and 2021. This limitation appeared to be an anomaly since other carriers by 2022 did not have similar limitations in conjunction with their telehealth benefits.

Carriers C.1. and C.2. included a new cost-sharing option that covered the first five in-network visits at 100%. Telehealth was included within the list of services eligible for this option. Carrier C.2. also included an additional benefit for virtual primary care services. The services were for individuals 18 or 19 years or older (variable age based on plan design). These virtual primary care services were provided only by virtual providers and were covered at 100% cost-share.

Furthermore, in 2022, carriers A.1. and A.2. submitted filings for a virtual program that provided coverage for a variety of virtual services at no copayment or coinsurance. There was also no deductible applied to these services, except for non-preventive services in high deductible health plans. There was an option to include an age limitation that ranged from 2 years to 19 years on participation in the program, and the services were limited to preventive care, non-preventive care primary, mental health care services, as well as an option to include rehabilitation physical therapy services.

Carriers D.1. and D.2. revised their benefits section to remove the virtual visits benefit and include all telemedicine/virtual visits under one telehealth benefit. They also tiered their cost-share structure so that a member would be able to receive a more beneficial cost-share if the member used a designated virtual provider for telehealth services. These two carriers included a rider in their 2022 filings that provided a debit card containing money to be used for certain medical expenses, including services that are provided by a designated virtual provider. Furthermore, carrier D.2. filed a rider that provided additional telehealth benefits to members with co-occurring behavioral and medical conditions. The services include therapist and coaching sessions for an eight

to ten-week period. These services were covered at no copayment, coinsurance, nor deductible, except for non-preventive services in high deductible health plans.

Individual Grandfathered Market

The individual grandfathered market in Maryland from 2019 to 2022 included carriers A.1., A.2., and B.1.

2019

The 2019 amendment for A.1. and A.2. was not approved by the MIA until the end of February 2019, so the previously approved amendment from 2017 was carried over into the first two months of 2019. These amendments were used to update base contracts going as far back as the mid-1990's, and these base contracts were silent on coverage of telehealth. However, exclusions for telephone consultations were located in the contracts, without any stipulations. Research into previously approved amendments did not reveal any instances of coverage of telehealth being added to the contracts.

In both the 2017 amendment and 2019 amendment, telehealth was not mentioned specifically. However, these carriers added new programs to the base contracts in the 2019 amendment that focused on weight loss, behavioral health, substance use disorder, and complex care. The programs specifically covered coaching and counseling sessions via telephone with cost-shares waived, in most circumstances, for the services. There were time limits placed on how long the member could participate in some of the programs with the cost-sharing waived, and cost-sharing was not waived for charges such as prescription drugs or facility charges. In the case of high deductible health plans, the deductible would not be waived for services not considered to be preventive services.

Carrier B.1 also submitted an amendment in 2019 to its previously approved base contracts that were approved several years in the past. Those base contracts were silent in regard to telehealth benefits, but an amendment in 2012 added a telehealth definition to the base contracts. This definition stated that telehealth consisted of "the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located." Furthermore, carrier B.1. stated in the 2012 amendment that services delivered through telehealth would be paid to the same extent as the corresponding face-to-face services.

2020

In the 2020 filings, carriers A.1. and A.2. did not make any changes to the base contracts to add general coverage for telehealth. The amendments in these filings contained the addition of a new support program for individuals with certain conditions or complex health care needs to the base contracts that included telemedicine services within the program. These services were subject to the same deductible, copayments, and coinsurance as stated in the schedules of benefits.

In regard to carrier B.1., the amendments filed in 2020 did not make reference to telehealth. However, three out of four of the schedules of benefits filed that year contained a statement that telehealth had the same copayment or coinsurance as face-to-face services. The fourth schedule of benefits was silent in regard to telehealth.

2021

The 2021 filings included changes to the telehealth benefit. The amendment filed by carriers A.1. and A.2. contained a definition of telehealth that stated telehealth was “the use of interactive audio, video, or other telecommunications or electronic technology for the purpose of consultation, diagnosis, or treatment of the patient that can be appropriately provided through telemedicine.” Furthermore, a reference to “the delivery of mental health care services to a patient in their home setting” was included in the definition. The provision went on to state that telehealth would be covered to the same extent as similar services for preventive care and treatment of illnesses, and telehealth is not subject to any dollar maximum or visit limitation. The exclusions specific to the benefit included audio-only telephone conversations, email, or facsimile transmissions. There was also a revision to the general exclusion of telephone consultations to state that it did not include any services that would be covered under the telehealth benefit.

In 2021, carrier B.1. included amendments to two different previously approved base contracts. The one amendment revised the telehealth benefit in a similar manner as carriers A.1. and A.2. However, this amendment included a stipulation that telehealth must involve “real-time two-way transfer of medical data and information.” The second amendment revised the telehealth definition in the same manner as carriers A.1. and A.2. This amendment specified that telehealth services were subject to the same charge as face-to-face services.

There were also slight differences in the revised limitations for telemedicine between carrier B.1.’s 2021 amendments. The one amendment contained a limitation that stated the equipment used for telemedicine had to be “of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter.” This limitation was not found in the second amendment.

However, both amendments were in agreement with telehealth exclusions, which included audio-only telephone conversations, emails, and facsimile transmissions between a provider and patient.

2022

The 2022 individual grandfathered filings for carriers A.1., A.2., and B.1. included amendments to the telehealth benefit and/or definition. The telehealth benefits/definitions were revised to include audio-only telephone conversations, without any stipulation that audio-only telephone conversations are included only when they result in a billable charge. In all three filings, the benefit/definition was amended to remove the reference to the member's home setting that was previously mentioned in regard to mental health services. The difference in B.1.'s benefit/definition amendments from the other two filings was that the amendments did not include a specific reference to substance use disorder services. It solely referred to mental health services.

Furthermore, the exclusions were revised in all three filings to remove reference to audio-only telephone conversations. The only remaining exclusions were email and facsimile transmissions between providers and patients. The limitation in the one B.1. amendment remained in 2022 regarding coverage of telehealth only when the equipment was of sufficient audio and video clarity as in person services. This same limitation was added in 2022 to the second B.1. amendment that did not previously contain the same stipulation.

There were no changes in any of the three carrier filings to the cost-share for telehealth services.

Appendix L: MIA Telehealth Carrier Survey

Appendix L

Telehealth Carrier Survey

The Maryland Insurance Administration ("Administration") is undertaking an analysis of coverage of telehealth services under health benefit plans offered by health insurance carriers in Maryland as part of the legislatively mandated study under Section 3 of Senate Bill 3, Chapter 71, Acts of 2021. To that end, the Administration is hereby initiating a market conduct action with respect to the Company under Code of Maryland Regulations ("COMAR") 31.04.20 and §§ 2-108, 2-205, and 2-207, in order to obtain the information below.

1. Using the chart in Appendix 1, for each listed modality of telehealth listed, indicate whether the service is currently covered under the carrier's health benefit plans, and whether the service was covered prior to January 1, 2020. If so, provide a brief description of the coverage provided, and indicate whether it is a standard benefit included in contracts, an optional benefit offered with most contracts, or a specialty benefit available in conjunction with only certain products. If the answers vary significantly between markets (large group, small group, individual, and student), please summarize the differences.

2. If the carrier has any products currently in development that would alter the responses provided for item 1) above, provide a description of those products, including the information requested in Appendix 1.

3. ***Provide the following information separately for products currently offered and for products offered prior to January 1, 2020***. If an answer varies significantly between markets or products within each time period, please summarize the differences.

a. Are telehealth services that are covered under the carrier's health benefit plans available from traditional "brick and mortar" providers who also provide services on an in-person basis?

b. Are telehealth services that are covered under the carrier's health benefit plans available from "telehealth-only" providers designated by the carrier? If so:

i. Are telehealth services covered only if received from a "telehealth-only" provider?
ii. Does the carrier arrange for these services to be provided through a third-party vendor or are the services provided in-house? Provide a brief description of the services.

c. If telehealth services from traditional "brick and mortar" providers are covered under the carrier's health benefit plans, are the services available through any generally available, non-public facing platform or technology, or are telehealth services only available through designated proprietary platforms?

d. Does the carrier arrange for providers or consumers to have access to telehealth services through a designated proprietary platform (regardless of whether the use of such platform is required to obtain coverage of telehealth services)? If so, provide a brief description of the arrangement and platform.

e. Does the carrier offer or cover telehealth services through any other types of delivery methods, such as telehealth kiosks at medical offices or other locations?

f. Does the carrier offer products that incentivize the use of telehealth services over in-person services for any situations, medical conditions, or particular covered services? Incentives may include, but are not limited to, waived or preferential cost-sharing, waiver of an otherwise applicable benefit limitation or exclusion, reduced administrative requirements, prompter service, etc. If such products are offered, provide a description of how the use of telehealth is incentivized under the carrier's products.

4. Does the carrier have any products currently in development that would incentivize the use of telehealth services over in-person services for any situations, medical conditions, or particular covered services? If so, provide a description of how the use of telehealth will be incentivized.

5. Does the carrier have any products currently in development that would require the use of telehealth for certain services or under certain circumstances, either in lieu of in-person services, or as a "telehealth-first" requirement? If so, provide a brief description of the proposed benefits and requirements.

6. Does the carrier track the number or percentage of in-network providers who offer telehealth services, either on the aggregate, or for certain types of providers? If so, provide the data. If the data can be sorted by specialty or geographic region without additional system programming, provide as much granularity as possible.

For purposes of this request, the Company shall include as "Maryland" policies: Individual and Group health benefit plan policies issued or delivered in the state of Maryland. "Health benefit plan" means a health benefit plan as defined in § 15–1401 of the Insurance Article for a large group plan, a health benefit plan as defined in §15-1201 for a small group plan, and a health benefit plan as defined in § 15–1301 of the Insurance Article for an individual plan.

The following should be excluded: Self-Insured Health Benefit Plans, Medicaid Plans, Federal Health Benefit Plans, Medicare supplement plans, Vision Plans, Dental Plans, and other excepted benefit plans.

Additionally, and in accordance with COMAR 31.04.20.05E, the Company is required to certify the accuracy of all information provided to the Administration by submitting a "Certificate of Compliance" signed by an officer of the Company and acknowledging that the information is "to the best of that individual's knowledge, information and belief, a full complete and truthful response to

the Commissioner's request" and that the "individual making the certification has undertaken an adequate inquiry to make the required certification". A copy of the Administration's standard Certificate of Compliance is included with this letter.

Please be advised that the Company's failure to timely and fully cooperate with this market conduct action including, but no limited to, the prompt and complete response to any and all inquiries by the Administration with reference to this market conduct action, may result in administrative action being taken pursuant to COMAR 31.04.20.09.

Your response and the Certificate of Compliance should be submitted to my attention by close of business on [30 days from date of letter]. If you should have any questions, I can be reached at 410-468-XXXX .
Page Break

Appendix M: MIA Telehealth Complaints

Appendix D

Telehealth Complaints

6/30/2022	Complaint Data - LH 1/1/2019 - 6/30/2022					
Complaint Number	**Date Received**	**Case Type**	**Coverage**	**Primary SubCoverage**	**Primary Reason**	**Primary Disposition**
M144 - Telemedicine						
2019						
MIA-2019-4-16-00106760	04/16/2019	Life & Health ("L & H")	0510 - Group	0559 - PPO; Large Group	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2019-4-29-00107167	04/29/2019	Life & Health ("L & H")	0510 - Group	0532 - Large Group; 556 SF/E	1015 - Denial of Claim	1300 - No Jurisdiction
SubTotal: 2						
2020						
MIA-2020-1-16-00115182	01/16/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO; 531 Small Group	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-1-16-00115184	01/16/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO; 531 Small Group	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-3-10-00116936	03/09/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-3-13-00117049	03/13/2020	Life & Health ("L & H")	0510 - Group	0556 - Self Funded/ERISA	1048 - Mental Health Parity	1235 - No Action Requested/Required
MIA-2020-3-20-00117224	03/20/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO; 538 Autism/PDD	1052 - Rehabilitative/habilitative Care	1300 - No Jurisdiction
MIA-2020-3-26-00117391	03/26/2020	Life & Health ("L & H")	0510 - Group	0532 - Large Group; 556 SF/E	1015 - Denial of Claim	1240 - Referred to Outside Agency/Dept
MIA-2020-3-30-00117471	03/30/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-3-31-00117528	03/31/2020	Life & Health ("L & H")	0505 - Individual	0543 - Mental Health	1015 - Denial of Claim; 1048 MHP	1230 - Claim Settled
MIA-2020-4-15-00117887	04/15/2020	Life & Health ("L & H")	0510 - Group	0532 - Large Group; 559 PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-4-20-00117968	04/20/2020	Life & Health ("L & H")	0510 - Group	0538 - Autism/PDD	1015 - Denial of Claim; 1052	1295 - Company Position Substantiated
MIA-2020-4-20-00117999	04/20/2020	Life & Health ("L & H")	0510 - Group	0556 - Self Funded/ERISA	1015 - Denial of Claim	1240 - Referred to Outside Agency/Dept
MIA-2020-5-15-00118714	05/15/2020	Life & Health ("L & H")	0510 - Group	0556 - Self Funded/ERISA	1015 - Denial of Claim	1300 - No Jurisdiction
MIA-2020-5-15-00118729	05/15/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2020-5-18-00118767	05/18/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1230 - Claim Settled
MIA-2020-5-22-00118897	05/22/2020	Life & Health ("L & H")	0510 - Group	0531 - Small Group; 543 MH; PPO	1015 - Denial of Claim;1018 OON	1295 - Company Position Substantiated
MIA-2020-6-3-00119208	06/03/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1005 - Unsatisfactory Settlement/Offer	1295 - Company Position Substantiated
MIA-2020-6-17-00119550	06/17/2020	Life & Health ("L & H")	0505 - Individual	0531 - Small Group; 543 MH	1015 - Denial of Claim	1295 - Company Position Substantiated

MIA-2020-6-18-00119581	06/18/2020	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
SubTotal: 18						
2021						
MIA-2021-1-12-00124282	01/12/2021	Life & Health ("L & H")	0510 - Group	0532 - Large Group	1015 - Denial of Claim; 1025 Delays	1300 - No Jurisdiction
MIA-2021-2-1-00124712	02/01/2021	Life & Health ("L & H")	0510 - Group	0559 - PPO	1025 - Delays;1053 Pediatric; 1018	1239 - Referred to Another State's Dept of Insurance
MIA-2021-4-9-00126602	04/09/2021	Life & Health ("L & H")	0510 - Group	0559 - PPO	1015 - Denial of Claim	1300 - No Jurisdiction
MIA-2021-4-16-00126770	04/16/2021	Life & Health ("L & H")	0510 - Group	0558 - HMO	1019 - Co-Pay Issues	1295 - Company Position Substantiated
MIA-2021-5-10-00127270	05/10/2021	Life & Health ("L & H")	0510 - Group	0559 - PPO	1025 - Delays; 1015 Denial of Claim	1208 - Compromised Settlement/Resolution
MIA-2021-6-9-00127949	06/09/2021	Life & Health ("L & H")	0505 - Individual	0522 - Exchange: 528 Gold; PPO	1015 - Denial of Claim	1295 - Company Position Substantiated
MIA-2021-9-13-00130189	09/13/2021	Life & Health ("L & H")	0510 - Group	0556 - Self Funded/ERISA	1015 - Denial of Claim	1300 - No Jurisdiction
MIA-2021-9-22-00130413	09/22/2021	Life & Health ("L & H")	0505 - Individual	0558 - HMO; 522; 527 Silver	1015 - Denial of Claim	1295 - Company Position Substantiated
SubTotal: 8						
2022						
MIA-2022-1-19-00133313	01/19/2022	Life & Health ("L & H")	0510 - Group	0556 - Self Funded/ERISA	1015 - Denial of Claim	1300 - No Jurisdiction
MIA-2022-4-20-00135866	04/20/2022	Life & Health ("L & H")	0510 - Group	0543 - Mental Health; 559 PPO	1015 - Denial of Claim	1239 - Referred to Another State's Dept of Insurance
SubTotal: 2						
Total: 30						

Appendix N: MIA Telehealth Responses from Other States

Telehealth Carrier Survey

The Maryland Insurance Administration ("Administration") is undertaking an analysis of coverage of telehealth services under health benefit plans offered by health insurance carriers in Maryland as part of the legislatively mandated study under Section 3 of Senate Bill 3, Chapter 71, Acts of 2021. To that end, the Administration is hereby initiating a market conduct action with respect to the Company under Code of Maryland Regulations ("COMAR") 31.04.20 and §§ 2-108, 2-205, and 2-207, in order to obtain the information below.

1. Using the chart in Appendix 1, for each listed modality of telehealth listed, indicate whether the service is currently covered under the carrier's health benefit plans, and whether the service was covered prior to January 1, 2020. If so, provide a brief description of the coverage provided, and indicate whether it is a standard benefit included in contracts, an optional benefit offered with most contracts, or a specialty benefit available in conjunction with only certain products. If the answers vary significantly between markets (large group, small group, individual, and student), please summarize the differences.

2. If the carrier has any products currently in development that would alter the responses provided for item 1) above, provide a description of those products, including the information requested in Appendix 1.

3. ***Provide the following information separately for products currently offered and for products offered prior to January 1, 2020***. If an answer varies significantly between markets or products within each time period, please summarize the differences.

a. Are telehealth services that are covered under the carrier's health benefit plans available from traditional "brick and mortar" providers who also provide services on an in-person basis?

b. Are telehealth services that are covered under the carrier's health benefit plans available from "telehealth-only" providers designated by the carrier? If so:

i. Are telehealth services covered only if received from a "telehealth-only" provider?
ii. Does the carrier arrange for these services to be provided through a third-party vendor or are the services provided in-house? Provide a brief description of the services.

c. If telehealth services from traditional "brick and mortar" providers are covered under the carrier's health benefit plans, are the services available through any generally available, non-public facing platform or technology, or are telehealth services only available through designated proprietary platforms?

d. Does the carrier arrange for providers or consumers to have access to telehealth services through a designated proprietary platform (regardless of whether the use of such platform is required to obtain coverage of telehealth services)? If so, provide a brief description of the arrangement and platform.

e. Does the carrier offer or cover telehealth services through any other types of delivery methods, such as telehealth kiosks at medical offices or other locations?

f. Does the carrier offer products that incentivize the use of telehealth services over in-person services for any situations, medical conditions, or particular covered services? Incentives may include, but are not limited to, waived or preferential cost-sharing, waiver of an otherwise applicable benefit limitation or exclusion, reduced administrative requirements, prompter service, etc. If such products are offered, provide a description of how the use of telehealth is incentivized under the carrier's products.

4. Does the carrier have any products currently in development that would incentivize the use of telehealth services over in-person services for any situations, medical conditions, or particular covered services? If so, provide a description of how the use of telehealth will be incentivized.

5. Does the carrier have any products currently in development that would require the use of telehealth for certain services or under certain circumstances, either in lieu of in-person services, or as a "telehealth-first" requirement? If so, provide a brief description of the proposed benefits and requirements.

6. Does the carrier track the number or percentage of in-network providers who offer telehealth services, either on the aggregate, or for certain types of providers? If so, provide the data. If the data can be sorted by specialty or geographic region without additional system programming, provide as much granularity as possible.

For purposes of this request, the Company shall include as "Maryland" policies: Individual and Group health benefit plan policies issued or delivered in the state of Maryland. "Health benefit plan" means a health benefit plan as defined in § 15–1401 of the

Insurance Article for a large group plan, a health benefit plan as defined in §15-1201 for a small group plan, and a health benefit plan as defined in § 15–1301 of the Insurance Article for an individual plan.

The following should be excluded: Self-Insured Health Benefit Plans, Medicaid Plans, Federal Health Benefit Plans, Medicare supplement plans, Vision Plans, Dental Plans, and other excepted benefit plans.

Additionally, and in accordance with COMAR 31.04.20.05E, the Company is required to certify the accuracy of all information provided to the Administration by submitting a "Certificate of Compliance" signed by an officer of the Company and acknowledging that the information is "to the best of that individual's knowledge, information and belief, a full complete and truthful response to the Commissioner's request" and that the "individual making the certification has undertaken an adequate inquiry to make the required certification". A copy of the Administration's standard Certificate of Compliance is included with this letter.

Please be advised that the Company's failure to timely and fully cooperate with this market conduct action including, but no limited to, the prompt and complete response to any and all inquiries by the Administration with reference to this market conduct action, may result in administrative action being taken pursuant to COMAR 31.04.20.09.

Your response and the Certificate of Compliance should be submitted to my attention by close of business on [30 days from date of letter]. If you should have any questions, I can be reached at 410-468-XXXX .

Appendix O: MIA July 7, 2022 MIA Title 31 Draft Regulation

Appendix F

July 7, 2022 Draft Regulations

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 44 Network Adequacy

Authority: Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) "Ambulatory infusion therapy center" means any location authorized to administer chemotherapy or infusion services on an outpatient basis.

[(2)**]** *(3)* – **[**(4)**]** *(5)* (text unchanged)

(6) "Drug and alcohol treatment program" means any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.

[(5)**]** *(7)* "Enrollee" means a person entitled to health care benefits from a carrier *under a policy or contract subject to Maryland law*.

[(6)**]** *(8)* "Essential community provider" means a provider that serves predominantly low-income or medically underserved individuals. "Essential community provider" includes:

(a) (text unchanged)

(b) Outpatient **[**behavioral**]** *mental* health and community based substance use disorder programs; **[**and**]**

(c) Any entity listed in 45 CFR §156.235(c)**[**.**]**; *and*

(d) School-based health centers.

[(7)**]** *(9)* – **[**(12)**]** *(14)* (text unchanged)

(15) "Hospital-based physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(13)**]** *(16)* – **[**(14)**]** *(17) (text unchanged)*

[(15)**]** *(18)* "Network adequacy waiver **[**request**]**" means **[**a written request from a carrier to the Commissioner wherein the carrier seeks**]** the Commissioner's **[**approval to be relieved**]** *decision to relieve a carrier* of *the obligation to comply with* certain network adequacy standards in this chapter for 1 year.

(19) "On-call physician" has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.

[(16)**]** *(20)* – **[**(21**]** *(25)* (text unchanged)

(26) "School-based health center" means a community health resource described in Health-General Article, § 19-2101, Annotated Code of Maryland that is located within an elementary, middle, or high school and approved by the Maryland State Department of Education.

[(22)**]** *(27)* – **[**(23)**]** *(28)* (text unchanged)

[(24)**]** *(29)* "Telehealth" **[**means:

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a provider to deliver a health care service within the scope of practice of the provider at a location other than the location of the patient.

(b) "Telehealth" does not include:

(i) An audio-only telephone conversation between a provider and a patient;

(ii) An electronic mail message between a provider and a patient; or

(iii) A facsimile transmission between a provider and a patient.**]** *has the meaning stated in Insurance Article, §15-139, Annotated Code of Maryland.*,

[(25)**]** *(30)* – **[**(26)**]** *(31)* (text unchanged)

[(27)**]** *(32)* "Waiting time" means the time from the initial request for health care services by an enrollee or by the enrollee's treating provider to the earliest date offered for the appointment for services *with a provider possessing the appropriate skill and expertise to treat the condition*.

.03 Network Adequacy Standards.

A. Sufficiency Standards.

(1) A carrier shall develop and maintain a network of providers in sufficient numbers, geographic locations, and practicing specialties to ensure enrollees have access to participating providers for the full scope of benefits and services covered under the carrier's health benefit plan.

(2) A carrier shall establish written policies and procedures to implement a process for addressing network deficiencies that result in an enrollee lacking access to any providers with the professional training and expertise necessary to deliver a covered service without unreasonable travel or delay.

(3) A carrier shall clearly define and specify referral requirements, if any, to specialty and other providers.

(4) A carrier shall take reasonable steps to ensure that participating providers provide physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.

(5) A carrier's written policies and procedures to monitor availability of services shall include how the carrier will monitor the availability of services for:

(a) Continuity of care;

(b) Individuals with physical or mental disabilities, including physical access issues; and

(c) Individuals with limited English proficiency, including diverse cultural and ethnic backgrounds.

(6) A carrier shall take reasonable steps to ensure services are delivered in a culturally competent manner to all enrollees, including enrollees:

(a) With limited English proficiency;

(b) With diverse cultural, racial, and ethnic backgrounds; and

(c) Of all genders, sexual orientations, and gender identities.

(7) A carrier shall identify, by zip code, the number of participating providers for each provider type code and specialty code listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland.

(8) The calculation of the number of participating providers described in §A(7) of this regulation:

(a) Shall include all participating providers who reported a specific provider type or specialty code when completing the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland; and

(b) May include additional participating providers identified by the carrier through other documented means.

(9) A carrier shall retain copies of its policies and procedures required by this chapter for a period of three years following the date the policies and procedures were last effective.

(10) At the request of the Commissioner, a carrier shall file with the Commissioner a copy of its current and retained past policies and procedures required by this chapter. A carrier may request a finding by the Commissioner that its policies and procedures are considered confidential commercial information.

B. Monitoring Sufficiency Standards.

(1) A carrier shall continuously monitor its provider network for compliance with this chapter and shall conduct internal compliance audits on at least a quarterly basis; and

(2) A carrier shall continuously verify and update its network directory consistent with Insurance Article, § 15-112, Annotated Code of Maryland and § 2799A-5of the Public Health Service Act.

[.03] *.04* Filing *and Content* of Access Plan.

A. Using the instructions on the Maryland Insurance Administration's website *for submission method and* to determine rural, suburban, and urban zip code areas, each carrier subject to this chapter shall file an annual access plan with the Commissioner **[**through the System for Electronic Rate and Form Filing (SERFF)**]** on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.

B. (text unchanged)

C. Each annual access plan filed with the Commissioner shall include *the following information in the standardized format described on the Maryland Insurance Administration's website*:

(1) An executive summary in the form set forth in Regulation **[**.09**]** *.11* of this chapter;

(2) (text unchanged)

(3) A description of out-of-network claims received by the carrier in the prior calendar year, which shall include:

(a) The percentage of total claims received that are out-of-network claims;

(b) The percentage of out-of-network claims received that are paid;

(c) The percentage of claims described in §C(3)(a) and (b) of this regulation that are for emergency services, on-call physicians, or hospital-based physicians;

(d) The percentage of total claims received that are out-of-network claims for:

(i) Subject to §F of this regulation, all enrollees with a residence in a zip code where less than 100% of enrollees have access to a provider within the applicable travel distance standard in Regulation .05 of this chapter for the provider type in the claim, listed by provider type for each of the rural, suburban, and urban areas;

(ii) Subject to §F of this regulation, the ten provider types with the highest number of out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area; and

(iii) Subject to §F of this regulation, the ten provider types with the highest percentage of total claims that are out-of-network claims for enrollees with a residence in each of the rural, suburban, and urban areas, listed by provider type and geographic area;

(e) For each provider type and geographic area described in §C(3)(d) of this regulation,

(i) The total dollar amount paid by the carrier for out-of-network claims received in that category; and

(ii) The total billed charges for out-of-network claims received in that category;

(f) For each provider type and geographic area described in §C(3)(d) of this regulation, the following information regarding requests to obtain a referral to an out-of-network provider in accordance with Insurance Article, § 15-830, Annotated Code of Maryland:

(i) The number of referral requests received;

(ii) The number of referral requests granted;

(iii) The percentage of out-of-network claims received for which a referral was requested;

(iv) The percentage of out-of-network claims received for which a referral was granted;

(v) The number of single case agreements entered between the carrier and an out-of-network provider; and

(vi) The percentage of out-of-network claims received for which a single case agreement was entered between the carrier and an out-of-network provider; and

(g) Any additional information deemed necessary by the carrier to provide context for the information described in §C(3)(a)-(f) of this regulation.

(4) A description of complaints received by the carrier in the prior calendar year relating to access to or availability of providers, which shall include:

(a) The total number of complaints made by enrollees relating to the wait time or distance of participating providers;

(b) The total number of complaints made by providers, whether or not under contract, relating to the wait time or distance of participating providers;

(c) The total number of complaints relating to the accuracy of the network directory;

(d) The total number of complaints relating to the dollar amount of reimbursement for out-of-network claims, including balance billing; and

(e) The percentage of complaints described in §C(4)(d) of this regulation that are for claims subject to the federal No Surprises Act.

(5) A description of the carrier's procedures, including training of customer service representatives, detailing how claims will be handled when participating providers are not available and an enrollee obtains health care services pursuant to Insurance Article, § 15-830, Annotated Code of Maryland;

(6) A description of the procedures that the carrier will utilize to assist enrollees in obtaining medically necessary services when no participating provider is available without unreasonable travel or delay, including procedures to coordinate care and to limit the likelihood of costs to the enrollee that exceed the amount that would have been incurred had the health care services been provided by a participating provider;

(7) A description of whether the carrier's provider contracts require health care providers to engage in appointment management, including procedures related to:

(a) No show policies;

(b) Patient appointment confirmation;

(c) Same day appointment slotting;

(d) Patient portals;

(e) Access to a provider performance dashboard to monitor appointment lag time, no show rate, bump rate (health care provider initiated cancelation of a scheduled appointment), and new patient appointments; and

(f) Weekly polling programs of providers to check for appointment availability;

(8) An indication of whether the network directory is searchable by covered benefit, for example, a hand physical therapist, or specific durable medical equipment;

(9) An indication of whether the carrier has a patient portal for enrollees to make health care appointments;

(10) A description of whether the carrier has a formal process for assisting enrollees who have been unsuccessful in using the network directory to locate an appropriate provider with the necessary skill and expertise to treat the enrollee's condition;

(11) A description of whether and how the carrier considered the role of public transportation in addressing the needs of enrollees who do not own a personal automobile when evaluating enrollees' access to care under the travel distance standards described in Regulation .05 of this chapter;

(12) A description of telehealth utilization as described in Regulation .08 of this chapter;

[(3)**]** *(13)* Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations **[**.04**]** *(.05)* — **[**.06**]** *(.07)* of this chapter; and

[(4)**]** *(14)* (text unchanged)

D. The Commissioner may require a carrier to include in the annual access plan the number of participating providers by zip code for certain provider type codes and specialty codes listed on the uniform credentialing form described in Insurance Article, § 15-112.1, Annotated Code of Maryland, if the Commissioner notifies the carrier in writing and identifies the particular provider type codes and specialty codes that shall be reported.

E. The description required by Insurance Article, §15-112(c)(4)(iii), Annotated Code of Maryland, shall identify whether the carrier has:

(1) Engaged in outreach to minority health care providers; and

(2) Offered financial incentives, such as payment towards loans previously incurred for health care provider education, to encourage health care providers to contract with the carrier.

F. The description required by Insurance Article, §15-112(c)(4)(iv), Annotated Code of Maryland, shall include:

(1) The number of primary care physicians, including pediatricians, family practitioners, and internists, who report to the carrier that they use any of the following languages in their practices:

(a) American Sign Language;

(b) Spanish;

(c) Korean;

(d) Chinese (Mandarin or Cantonese);

(e) Tagalog; or

(f) French;

(2) A description of outreach efforts to recruit and retain providers from diverse cultural, racial, or ethnic backgrounds;

(3) A copy of the most recent enrollees' language needs assessment made by or on behalf of the carrier, if one was made;

(4) A copy of the most recent demographic profile of the enrollee population made by or on behalf of the carrier, if one was made;

(5) A copy of any analysis or assessment made of provider network requirements based on an assessment of language needs or demographic profile of the enrollee population;

(6) A copy of any provider manual provisions that describe requirements for access to individuals with physical or mental disabilities; and

(7) Copies of policies and procedures designed to ensure that the provider network is sufficient to address the needs of both adult and child enrollees, including adults and children with:

(a) Limited English proficiency or illiteracy;

(b) Diverse cultural, racial, or ethnic backgrounds;

(c) Physical or mental disabilities; and

(d) Serious, chronic, or complex health conditions.

G. For a Group model HMO plan, the geographic area data described in §C(3) of this regulation shall be reported based on the enrollee's place of employment, if the enrollee gains eligibility for participation in the plan due to place of employment.

[.04] .05 Travel Distance Standards.

A. Sufficiency Standards.

(1) Standard and Methodology

[(1)**]** *(a)* Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, **[**behavioral**]** *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area.

(b) The distances listed in §A(5) of this regulation shall be:

(i) **[**measured**]** *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence**[**.**]***; and*

(ii) Calculated based on road travel distance.

(c) Except for those provider types excluded under §A(3) of this regulation, for each provider type and facility type included on the carrier's provider panel, the carrier shall:

(i) Map the practicing locations of every participating provider within the geographic area served by the carrier's network or networks;

(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider location;

(iii) For each zip code, identify the total number of enrollees residing in the zip code and the number of enrollees residing within an area where the applicable distance standard is not met;

(iv) For each zip code, calculate the percentage of enrollees residing within an area where the applicable distance standard is met;

(v) For each zip code that includes enrollees for whom the applicable travel distance standard is not met, calculate the average distance to the closest provider or facility for all enrollees residing in the zip code;

(vi) For each of the urban, rural, and suburban areas identify the total number of enrollees residing in the geographic area;

(vii) For each of the urban, rural, and suburban areas identify the total number of enrollees residing within an area where the applicable distance standard is not met; and

(viii) For each of the urban, rural, and suburban areas identify the percentage of enrollees residing within an area where the applicable distance standard is met.

(d) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §A(3) of this regulation showing the practicing locations of participating providers, and identifying either the geographic areas within each zip code where the applicable distance standard is not met, or the locations of enrollees with a residence outside the applicable distance standard;

(ii) For any facility types listed in §A(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide adolescent services; and

(iii) For any facility types listed in §A(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(e) A carrier shall report each number and percentage described in §A(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.

(2) – (3) (text unchanged)

(4) All other providers and facility types *included on the carrier's provider panel but* not listed in the chart in §A(5) of this regulation*, including physical therapists and licensed dietitian-nutritionist,* shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60
Cardiovascular Disease	10	20	60
Child Psychiatry	*10*	*25*	*60*
Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
Geriatric Psychiatry	*10*	*25*	*60*
Gynecology, OB/GYN	5	10	30
[Gynecology Only	15	30	75]
Licensed Clinical Social Worker	10	25	60
Licensed Professional Counselor	*10*	*25*	*60*
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30
Physiatry, Rehabilitative Medicine	15	30	75
Physician Certified in Addiction Medicine	*10*	*25*	*60*
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician *(non-pediatric)*	5	10	30
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All Other licensed or certified providers under contract with a carrier not listed	15	40	90
Facility Type:			
Acute Inpatient Hospitals	10	30	60
Ambulatory Infusion Therapy Centers	*10*	*30*	*60*
Critical Care Services — Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Drug and Alcohol Treatment Program	*10*	*25*	*60*

Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60]
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Residential Crisis Services	*10*	*30*	*60*
Skilled Nursing Facilities	10	30	60
Substance Use Disorder Residential Treatment Facility	*10*	*25*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	10	25	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	90

B. Group Model HMO Plans Sufficiency Standards.

(1) Standard and Methodology

[(1)] *(a)* Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care physicians, specialty providers, [behavioral] *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(5) of this regulation for each type geographic area.

(b) The distances listed in §B(5) of this regulation shall be:

(i)[measured] *Measured* from the *practicing location of the provider or facility to the* enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan[.]*; and*

(ii) Calculated based on road travel distance.

(c) Except for those provider types excluded §B(3) of this regulation, for each provider type and facility type included on the group model HMO's provider panel, the carrier shall:

(i) Map the practicing locations of every participating provider within the geographic area served by the group model HMO's network or networks;

(ii) Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations;

(iii) For each zip code, identify the total number of enrollees with a residence or place of employment in the zip code and the number of enrollees with a residence or a place of employment within an area where the applicable distance standard is not met;

(iv) For each zip code, calculate the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met;

(v) For each zip code that includes enrollees for whom the applicable travel distance standard is not met, calculate the average distance to the closest provider or facility for all enrollees with a residence or place of employment within the zip code;

(vi) For each of the urban, rural, and suburban areas identify the total number of enrollees with a residence or place of employment in the geographic area;

(vii) For each of the urban, rural, and suburban areas identify the number of enrollees with a residence or place of employment within an area where the applicable distance standard is not met; and

(viii) For each of the urban, rural, and suburban areas identify the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met.

(d) When calculating the number or percentage of enrollees with a place of employment within an area or zip code under §B(1)(c)(iii)-(viii) of this regulation, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO's health benefit plan from their place of employment.

(e) A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:

(i) Geo-access maps for each provider type and facility type except for those excluded under §B(3) of this regulation showing the practicing locations of participating providers, and identifying either the geographic areas within each zip code where the applicable distance standard is not met, or the locations of enrollees with a residence or place of employment outside the applicable distance standard;

(ii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide adolescent services; and

(iii) For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier's provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.

(f) A carrier shall report each number and percentage described in §B(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.

(2) – (3) (text unchanged)

(4) All other provider and facility types *included on the carrier's provider panel, but* not listed in the chart at §B(5) of this regulation, *including physical therapists and licensed dietitian-nutritionist,* shall individually be required to meet maximum distances standards of [15] *20* miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60
Cardiovascular Disease	15	25	60
Child Psychiatry	*15*	*30*	*75*
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Geriatric Psychiatry	*15*	*30*	*75*
Gynecology, OB/GYN	15	20	45
[Gynecology Only	15	30	60]
Licensed Clinical Social Worker	15	30	75
Licensed Professional Counselor	*15*	*30*	*75*
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45
Physiatry, Rehabilitative Medicine	15	30	75
Physician Certified in Addiction Medicine	*15*	*30*	*75*
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care Physician *(non-pediatric)*	15	20	45
Psychiatry	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
Facility Type:			

Acute Inpatient Hospitals	15	30	60
Ambulatory Infusion Therapy Center	*15*	*30*	*60*
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Drug and Alcohol Treatment Program	*15*	*30*	*60*
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60]
Outpatient Mental Health Clinic	*15*	*30*	*60*
Outpatient Substance Use Disorder Facility	*15*	*30*	*60*
Pharmacy	5	10	30
Residential Crisis Services	*15*	*30*	*60*
Skilled Nursing Facilities	15	30	60
Substance Use Disorder Residential Treatment Facility	*15*	*30*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	15	30	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

C. Essential Community Providers.

(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include*:*

(a)[at] *At* least 30 percent of the available essential community providers *providing medical services* in each of the urban, rural, and suburban areas[.];

(b) At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and

(c) At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.

(2) Methodology for calculating essential community provider inclusion standard.

(a) Except as provided in §§C(2)(b) and (c) of this regulation, a carrier shall use the MHBE ECP Network Inclusion Calculation Methodology that is described in the Instructions on Meeting the Essential Community Provider Plan Certification Standard guidance provided by the Maryland Health Benefit Exchange, which is current as of the date three months prior to the due date of the annual access plan.

(b) The calculation described in §C(2)(a) of this regulation shall be performed separately for essential community providers providing medical services, mental health services, and substance use disorder services in each of the urban, rural, and suburban areas.

(c) If the Maryland Health Benefit Exchange changes the MHBE ECP Network Inclusion Calculation Methodology after the effective date of this regulation, a carrier may not use the revised methodology to calculate the essential community provider inclusion standard in §C(1) of this regulation unless the Commissioner has approved the revised methodology for this purpose.

[(2)] *(3)* – [(3)] *(4)* (text unchanged)

[.05] *.06* Appointment Waiting Time Standards.

A. Network capacity.

(1) Each carrier shall create and utilize written policies and procedures to monitor the availability of services.

(2) On a semiannual basis, each carrier shall make available to its enrollees the median wait times to obtain the following in-person appointments with a participating provider as measured from the date of the initial request to the date of the earliest available in-person appointment:

(a) Urgent care for medical services;
(b) Inpatient urgent care for mental health services;
(c) Inpatient urgent care for substance use disorder services;
(d) Outpatient urgent care for mental health services;
(e)Outpatient urgent care for substance use disorder services;
(f) Routine primary care;
(g) Preventive care/well visits;
(h) Non-urgent specialty care;
(i) Non-urgent mental health care; and
(j) Non-urgent substance use disorder care.

(3) To monitor availability of providers, a carrier shall:

(a) Utilize a survey tool with enrollees;

(b) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available in-person appointments; and

(c)Retain documentation of the efforts described in §A(3)(a) – (b) of this regulation.

(4) The survey tool described in §A(3)(a) of this regulation shall:

(a) Utilize a statistically valid method to ensure that survey respondents are selected in a random manner;

(b) Ask enrollees to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an in-person appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; and

(c) Ensure a minimum sample size of responsive answers for each appointment type listed in §A(2) of this regulation that is equivalent to the lesser of:

(i) Ten percent of claims received by the carrier for that appointment type in the preceding calendar year; or

(ii) One hundred answers.

(5) The minimum sample size for the random selection of provider offices described in §A(3)(c) of this regulation shall be equivalent to the lesser of:

(a) Ten percent of the participating providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation; or

(b) One hundred provider offices.

(6) The median wait times described in §A(2) of this regulation shall be calculated by:

(a) Determining the median wait time based on the results of the enrollee surveys described in §A(3)(b) of this regulation and multiplying that number by 0.25;

(b) Determining the median wait time based on the direct contacts with provider offices described in §A(3)(c) of this regulation and multiplying that number by 0.75; and

(c) Adding the results in §A(6)(a) and §A(6)(b) of this regulation.

[A.**]** *B.* Sufficiency Standards.

(1) On a semiannual basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the enrollee surveys and the direct contacts with provider offices described in §A(3)(a)-(b) of this regulation.

[(1)**]** *(2)* Subject to the exceptions in **[**§B**]** *§§C and D* of this regulation, **[**each carrier's provider panel shall meet the waiting time standards listed in §E of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel**]** *if a carrier's provider panel fails to meet the waiting time standards listed in §E of this regulation for at least 90% of appointments in each category, the carrier shall notify the Administration within 10 business days identifying the deficiency in the provider network and the efforts that have been taken or will be taken to correct the deficiency*.

[(2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards listed in §C of this regulation.**]**

[B.**]** *C.* Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or **[**behavioral**]** *mental* health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider's license, certification, or other authorization.

D. A visit scheduled in advance in accordance with §C of this regulation may be disregarded when determining compliance with the waiting time standards listed in §E of this regulation.

[C.**]** *E.* Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care *for medical services* **[** (including medical, behavioral health, and substance use disorder services)**]**	72 hours
Inpatient urgent care for mental health services	*72 hours*
Inpatient urgent care for substance use disorder services	*72 hours*
Outpatient urgent care for mental health services	*72 hours*
Outpatient urgent care for substance use disorder services	*72 hours*
Routine primary care	15 calendar days
Preventive **[**visit**]** *care*/well visit	30 calendar days
Non-urgent specialty care	30 calendar

	days
Non-urgent mental health care	*10 calendar days*
Non-urgent [behavioral health/] substance use disorder [services] *care*	10 calendar days

[.06] *.07* Provider-to-Enrollee Ratio Standards.

A. (text unchanged)

B. The provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider for:

(1) – (3) (text unchanged)

(4) 2,000 enrollees for [behavioral] *mental* health care or services; and

(5) (text unchanged)

C. The ratios described in §B of this regulation shall be calculated based on:

(1) The number of enrollees covered under all health benefit plans issued by the carrier in Maryland that use that provider panel; and

(2) The number of providers in that provider panel with practicing locations:

(a) In Maryland; or

(b) Within the applicable maximum travel distance standard specified in Regulation .05 of this chapter outside the geographic boundaries of Maryland.

.08 Telehealth.

A. Telehealth Utilization Data Reporting.

(1) A carrier shall report the following data on telehealth utilization for the calendar year prior to submission of the annual access plan:

(a) The total number of in-network telehealth claims for each provider type and facility type listed in Regulation .05 of this chapter in each of the urban, rural, and suburban areas and in each Maryland county and Baltimore City; and

(b) The percentage of total in-network claims for each provider type and facility type listed in Regulation .05 of this chapter in each of the urban, rural, and suburban areas and in each Maryland county and Baltimore City that are in-network telehealth claims.

(2) The geographic area for claims data described in §A(1) of this regulation shall be based on the enrollee's place of residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan.

B. Travel Distance Credit.

(1) Subject to approval by the Commissioner as described in §B(5) of this regulation, when calculating the enrollee travel distance for each provider type under Regulation .05A and B of this chapter, a carrier may apply a per-enrollee telehealth mileage credit in a geographic area where the applicable maximum travel distance standard is not met as measured from the practicing location of the nearest provider to the enrollee's place of residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan.

(2) The telehealth mileage credit described in §B(1) of this regulation shall be:

(a) Five miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in an urban geographic area;

(b) Ten miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in a suburban geographic area; and

(c) Fifteen miles for an enrollee with a residence or, for a group model HMO, place of employment from which the enrollee gains eligibility for participation in the health benefit plan, in a rural geographic area.

(3) The telehealth mileage credit described in §B(1) of this regulation may be applied to a maximum of 10% of enrollees for each provider type in each of the urban, rural, or suburban geographic areas.

(4) A carrier seeking to apply the telehealth mileage credit described in §B(1) of this regulation shall identify:

(a) Each provider type and geographic area to which the credit is being applied;

(b) The percentage of enrollees for which the carrier met the travel distance standard for the provider type and geographic area before the credit was applied; and

(c) The percentage of enrollees for which the carrier met the travel distance standard for the provider type and geographic area after the credit was applied.

(5) The Commissioner may approve the telehealth mileage credit described in §B(1) of this regulation if the carrier sufficiently demonstrates that it provides coverage for and access to clinically appropriate telehealth services from participating providers for the provider type and geographic area to which the credit is being applied, in accordance with the documentation requirements of §D of this regulation.

C. Appointment Waiting Time Credit.

(1) Subject to approval by the Commissioner as described in §C(3) of this regulation, when determining whether the carrier's provider panel meets the waiting time standards under Regulation .06E of this chapter for at least 90% of appointments

in each category, a carrier may apply a telehealth credit of up to 10% for each appointment category where the standard is not met.

(2) A carrier seeking to apply the telehealth credit described in §C(1) of this regulation shall identify:

(a) Each appointment type to which the credit is being applied;

(b) The percentage of appointments for which the carrier met the waiting time standard before the credit was applied; and

(c) The percentage of appointments for which the carrier met the waiting time standard after the credit was applied.

(3) The Commissioner may approve the telehealth credit described in §C(1) of this regulation if a carrier sufficiently demonstrates, in accordance with the documentation requirements of §D of this regulation, that:

(a) The carrier provides coverage for and access to clinically appropriate telehealth services from participating providers for the appointment type to which the credit is being applied; and

(b) The carrier establishes, maintains, and adheres to written policies and procedures to assist enrollees for whom a telehealth service is not clinically appropriate, not available, or not accessible with obtaining timely access to an in-person appointment within a reasonable travel distance with:

(i) A participating provider; or

(ii) A nonparticipating provider at no greater cost to the enrollee than if the service was obtained from a participating provider.

D. Required Documentation.

(1) A carrier seeking to apply the telehealth credit described in §B(1) or C(1) of the regulation shall submit the following documentation to demonstrate that it provides coverage for and access to clinically appropriate telehealth services as described in §§B(5) and C(3)(a) of this regulation:

(a) A description of any requirements imposed or incentives provided for participating providers to offer telehealth services;

(b) A detailed description of all telehealth services offered under the health benefit plans issued by the carrier in Maryland that use the provider panel including:

(i) Telehealth modalities covered;

(ii) Types of platforms through which participating providers may deliver telehealth;

(iii) Whether the carrier arranges for telehealth services to be available on a 24/7 basis, and which types of services are provided on this basis;

(iv) Whether the carrier arranges for telehealth kiosks to be installed and maintained in convenient locations throughout Maryland; and

(v) The specific services available through telehealth for each provider type and appointment type to which the telehealth credit is being applied;

(c) Evidence that telehealth is clinically appropriate and available for the services performed by each provider type and for each appointment type to which the telehealth credit is being applied, which may include:

(i) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to telehealth claims for all provider types or appointment types;

(ii) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to all claims for the same provider type or appointment type;

(iii) Survey results or attestations from participating providers indicating that telehealth is offered for the services performed by the specific provider type or for the specific appointment type;

(iv) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services for the specific provider type or appointment type; and

(v) Other documentation that, in the discretion of the Commissioner, demonstrates the clinical appropriateness and availability of telehealth services for the provider type or appointment type to which the credit is being applied; and

(d) For the telehealth mileage credit described in §B(1) of this regulation, evidence that telehealth services in general are available and accessible in the zip codes where the telehealth mileage credit is being applied to enrollee residence or place of employment, which may include:

(i) Actual telehealth utilization data comparing the ratio of telehealth claims to in-person claims for all types of services on the aggregate in the geographic area of the zip codes where the credit is being applied to the ratio of telehealth claims to in-person claims for all types of services on the aggregate statewide;

(ii) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services in general in the geographic area where the credit is being applied; and

(iii) Other documentation that, in the discretion of the Commissioner, demonstrates the availability and accessibility of telehealth services in the zip codes where the credit is being applied.

(2) A carrier seeking to apply the telehealth credit described in §C(1) of the regulation shall submit the following documentation to demonstrate that it establishes, maintains, and adheres to written policies and procedures to assist enrollees with obtaining timely access to an in-person appointment as described in §C(3)(b) of this regulation:

(a) Copies of the actual written policies and procedures;

(b) A description of any information, outreach, and educational materials the carrier provides to enrollees informing them of the assistance available from the carrier to assist with obtaining a timely appointment;

(c) A description of whether the carrier provides assistance on a 24/7 basis to guide enrollees needing urgent care after normal business hours to an appropriate provider, including assistance provided through a customer service telephone option or a contracted telehealth triage service; and

(d) Evidence that the carrier ensures, in practice, that enrollees are able to obtain timely access to an in-person appointment as described in §C(3)(b) of this regulation, which may include:

(i) Documentation of the number of enrollees the carrier assisted with getting appointments within the applicable waiting time standard under Regulation .06E of this chapter;

(ii) Documentation of the number of appointments with a nonparticipating provider for the appointment type to which the credit is being applied where the enrollee received services at no greater cost than if the service was obtained from a participating provider;

(iii) Enrollee survey results indicating satisfaction with the carrier's efforts to provide assistance with obtaining a timely appointment; and

(iv) Other documentation that, in the discretion of the Commissioner, demonstrates that the carrier regularly assists enrollees in obtaining timely in-person appointments.

[.07] *.09 Network Adequacy* Waiver [Request] Standards.

A. [A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.] *If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05-.07 of this chapter, the carrier shall provide the following information to the Commissioner as part of the annual access plan:*

(1) A description of any network adequacy waiver previously granted by the Commissioner;

(2) An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with or otherwise include in its network to satisfy each unmet standard;

(3) A description of the methodology used to calculate the estimated number of providers in §A(2) of this regulation;

(4) A list of physicians, other providers, or health care facilities related to each unmet standard and within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(5) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(6) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(7) An analysis of any trends in the reasons given by physicians, providers, or health care facilities for refusing to contract with the carrier, and a description of the carrier's proposals or attempts to address those reasons and improve future contracting efforts;

(8) Identification of all incentives the carrier offers to providers to join the network;

(9) If applicable, a substantiated statement that there are insufficient numbers of physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier failed to meet a standard;

(10) A detailed description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;

(11) A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard;

(12) An explanation of any other mitigating factors that the carrier requests the Commissioner to consider; and

(13) An attestation to the accuracy of the information provided in relation to each unmet standard.

B. The Commissioner may find good cause to grant [the] *a* network adequacy waiver [request] *of one or more of the standards specified in Regulations .05-.07 of this chapter,* if *the information provided by* the carrier *under §A of this regulation* demonstrates that*:*

(1) [the] *The* physicians, other providers, or health care facilities necessary for an adequate network:

[(1)] *(a)* – [(3)] *(c)* (text unchanged)

[(4)] *(d)* Are unable to reach agreement with the carrier*; or*

(2) The reported failure to meet a standard is a result of limitations or constraints with the measurement methodology rather than an actual deficiency in the network.

C. [A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

(1) A description of any waiver previously granted by the Commissioner;

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;

(6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and

(7) An attestation to the accuracy of the information contained in the network adequacy waiver request.] *The Commissioner shall post a list of all network adequacy waivers that are granted for each annual access plan on the Maryland Insurance Administration's website.*

[.08] .*10* Confidential Information in Access Plans.

A. Subject to §15-802 of the Insurance Article, Annotated Code of Maryland, the following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

(1) [Methodology] *Proprietary methodology* used to annually assess the carrier's performance in meeting the standards established under this chapter;

(2) [Methodology] *Proprietary methodology* used to annually measure timely access to health care services; and

(3) (text unchanged)

B. A carrier submitting an access plan or [a] *supplemental information required for the* network adequacy waiver [request] *standards* may submit a written request to the Commissioner that specific information included in the plan [or request] not be disclosed under the Public Information Act and shall:

(1) – (2) (text unchanged)

C. – D. (text unchanged)

[.09] .*11* Network Adequacy Access Plan Executive Summary Form.

A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the *following* network sufficiency results for the health benefit plan service area [as follows] *in the standardized format described on the Maryland Insurance Administration's website*:

(1) Travel Distance Standards.

(a) For each provider type *and facility type* listed in Regulation [.04] *.05 of this chapter*, list the percentage of enrollees for which the carrier met the travel distance standards, in the following format, *with provider types listed first in alphabetical order, followed by facility types in alphabetical order*:

	Urban Area	Suburban Area	Rural Area
[Primary Care Provider] *Provider Type*			
[Specialty Provider] *Facility Type*			

(b) All provider and facility types described in §§A(4) and B(4) of Regulation .05 of this chapter and included on the carrier's provider panel shall be listed individually in the chart described in §A(1)(a) of this regulation with the corresponding data for that specific type of provider or facility.

(c) If the telehealth mileage credit described Regulation .08B of this chapter was applied when calculating the percentage of enrollees for which the carrier met the travel distance standards, the carrier shall:

(i) Note the particular provider types and geographic areas to which the credit was applied by including an asterisk in the chart; and

(ii) Include a corresponding footnote stating "As permitted by Maryland regulations, a telehealth mileage credit was applied to up to 10% of enrollees for each provider type noted with an asterisk in each of the urban, rural, or suburban geographic areas. The mileage credit is 5 miles for urban areas, 10 miles for suburban areas, and 15 miles for rural areas."

[(b)] *(d)* – [(c)] *(e)* (text unchanged)

[(d)] *(f)* List the total number of essential community providers in the carrier's network *in each of the urban, rural, and suburban areas providing:*

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

[(e)] *(g)* List the total percentage of essential community providers available in the health benefit plan's service area that are participating providers *for each of the nine categories described in §A(1)(f) of this regulation.*

(h) List the total number and percentage of local health departments in the carrier's network providing:

(i) Medical services;

(ii) Mental health services; and

(iii) Substance use disorder services.

(2) Appointment Waiting Time Standards.

(a) For each appointment type listed in Regulation [.05] *.06*, list the [percentage of enrollees for which the carrier met the appointment wait time standards] *calculated median wait time to obtain an appointment with a participating provider*, in the following format:

Appointment Waiting Time Standard Results	
Urgent care *for medical services* [— within 72 hours]	
Inpatient urgent care for mental health services	
Inpatient urgent care for substance use disorder services	
Outpatient urgent care for mental health services	

Outpatient urgent care for substance use disorder services	
Routine primary care [— within 15 calendar days]	
[Preventative Visit] *Preventive care*/Well Visit[— within 30 calendar days]	
Non-urgent specialty care [— within 30 calendar days]	
[Non-urgent ancillary services — within 30 calendar days]	
Non-urgent [behavioral] *mental* health[/substance use disorder services — within 10 calendar days] *care*	
Non-urgent substance use disorder care	

(b) [List the total percentage of telehealth appointments counted as part of the appointment waiting time standard results]. *If the telehealth credit described Regulation .08C of this chapter was applied when determining whether the carrier's provider panel met the waiting time standards under Regulation .06E of this chapter for at least 90% of appointments in any category, the carrier may include a statement on the executive summary indicating that the enrollee may obtain a timelier covered appointment than the median reported wait time for that category if telehealth is elected.*

(c) If the carrier arranges for telehealth services to be provided from participating providers on a 24/7 basis for an appointment type listed in Regulation .06 of this chapter, the carrier may include a statement on the executive summary disclosing the availability of those services.

(3) Provider-to-Enrollee Ratio Standards.

(a) (text unchanged)

(b) For all other carriers, [list whether the percentage of provider-to-enrollee ratios meet the] *summarize the network performance for each* provider-to-enrollee ratio [standards] *standard* listed in Regulation [.06] *.07* of this chapter *by listing the calculated number of providers in the provider panel, rounded to the nearest whole number,* for each of the following categories *of enrollees*:

(i) – (iii) (text unchanged)

(iv) 2,000 enrollees for [behavioral] *mental* health care or service; and

(v) (text unchanged)

B. (text unchanged)

Appendix P: MHCC Town Halls

Exhibit H: Telehealth Town Hall Written Comments

The MHCC convened two informal Telehealth Town Halls (Town Halls) with providers (July 14th) and payers (July 20th) to discuss the current and future state of telehealth in the delivery of somatic and behavioral health care. The MHCC invited stakeholders to provide verbal or written comments. Written comments follow:

Amerigroup Maryland, Inc.

Submitted by Kathleen Garrett Loughran

Below is some additional information on audio-only that may be helpful to the telehealth workgroup. I have also provided Amerigroup's, which is an affiliate of Elevance Health (previously known as "Anthem"), position on the Consolidate Act as it pertains to audio-only.

The Consolidated Appropriations Act of 2021 allows for reimbursement of audio-only telehealth services for the diagnosis, evaluation, or treatment of mental health conditions. Following are the requirements for reimbursement:

- The patient is located in their home at the time of service;
- The distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunications system that includes video; and the patient is not capable of, or does not consent to, the use of video technology for the service; and
- The patient has had an in-person visit 6 months prior to the audio-only visit and receives an in-person visit every 12 months thereafter.

The CAA of 2022 extends a waiver of the above requirements for 151 days after the PHE expires. The proposed Advancing Telehealth Beyond COVID-19, which just passed the House last night, would extend the waivers through December 31, 2024. Elevance Health supports the use of audio-only for mental health conditions but does not support in-person visit requirements because it can create a barrier to accessing care.

The Coordinating Center

Submitted by Robyn Elliott

Telehealth Becomes Integrated into Care

The Coordinating Center appreciates the opportunity to submit comments regarding the MHCC study on telehealth. Our organization's mission is to support our clients in the community in achieving "their aspirations for independence, health, and meaningful community life." We provide care coordination to individuals with complex medical conditions and/or disabilities under

10 different care management programs, including several home and community-based waivers through Maryland's Medical Assistance Program, sponsored by the Maryland Department of Health.

Since the COVID-19 pandemic, our clients have increased their utilization of telehealth for routine medical appointments to help them manage their chronic conditions. With nearly 10,000 clients, 94% of whom are receiving services through Medicaid, we serve a population who has limited resources to support patient access and engagement, due to distance, lack of transportation, conflicting obligation and/or other barriers.

Telehealth for medical appointments increases access to health care, remote patients can more easily access care and improves health outcomes as it allows patients to be diagnosed and treated earlier, often improving health outcomes and providing a reduction in hospital stays. Telehealth also addresses the shortages in health care, as specialists can more efficiently manage patient volumes. Also, many telehealth platforms will help increase engagement, empowering the patient to take a more active role in their health care.

While face-to-face care management services is our preferred method of engagement at The Coordinating Center, we support parity for the provision of telehealth services for care management services when those services are clinically appropriate. In programs where care management is voluntary, telehealth often increases participation and engagement if we can visualize the patient in real-time without having to schedule a home visit in the future. In programs where we serve individuals over a long period of time, the combination of in-person visits and telehealth visits can increase participation and result in reaching their health care goals in a more time-efficient manner. We recognize that for a subset of our population – coworkers and clients, telehealth is their preferred method of service delivery.

High Consumer Satisfaction with Telehealth

Recently we asked the following question as part of our client satisfaction survey: **"***Did you receive a virtual visit last year? If yes, how would you rate your virtual visit experience?" A*bout 400 survey respondents had received a virtual visit, and 91.34% reported being satisfied and very satisfied with the experience. The satisfaction ranges from 80 to 97% across all programs.

Telehealth Utilization Remains High

Below is the virtual visit data of all programs at The Coordinating Center combined. Based on approximately 5,000 clients which is half our client base. Some clients may have received one, and some may have received multiple visits. Data is approximate, as there were some challenges documenting early on during the pandemic.

The Coordinating Center:
Data represents 50% of The Coordinating Center Clients.
January 1, 2020 – June 30, 2022

Quarter Year	Number of visits logged
Q1 2020	658
Q2 2020	6204
Q3 2020	6068
Q4 2020	6649
Q1 2021	6681
Q2 2021	6887
Q3 2021	6643
Q4 2021	7217
Q1 2022	7359
Q2 2022	6660

The number of telehealth visits has remained high throughout the course of the pandemic. In fact, the current level of visits is higher than at the beginning of the pandemic. This shows that telehealth has become integrated into care, even after COVID restrictions has been eased.

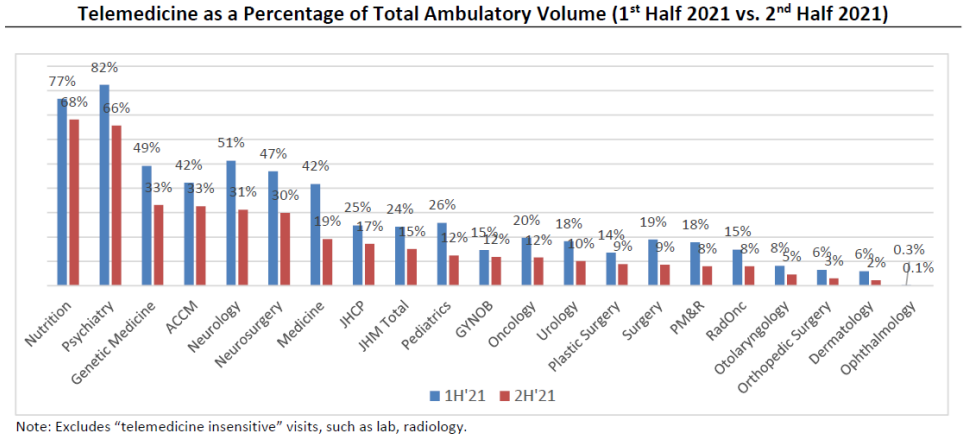
Johns Hopkins Medicine

Brian Hasselfeld, MD, *Sr. Medical Director, Digital Health and Innovation, Office of Johns Hopkins Physicians*

Since March 2020, Johns Hopkins Medicine has completed nearly 1.5 million synchronous, ambulatory telehealth visits to over 400,000 unique patients, of which approximately 87% has been to patients with home addresses in the state of Maryland.

This virtual care has been across the entire breadth of primary care, mental health, and specialty services. Of our nearly 1.5 million total visits, ~78% were in clinical areas outside our Department of Psychiatry, and nearly half (~47%) were in clinical areas outside of psychiatry, general internal medicine, family practice, or general pediatrics. As can be seen in the graph below, telemedicine has been an invaluable tool across all clinical areas, including many critical specialty areas such as genetics, pre- and perioperative medicine, neurology, and neurosurgery. In addition, over one-third of our telemedicine care, representing over half a million visits, has been delivered by frontline providers other than physicians. We view telemedicine as a clinical tool, to be used by all types of clinicians and patients in all clinical specialties when appropriate for that particular patient and that particular patient's clinical conditions. Increased regulation of what kind of care is or is not appropriate for telemedicine (or what kinds of providers should or should not use telemedicine) will negatively impact patient access, especially for those who have faced historical and current inequities in health care access.

Against the backdrop of this rapid evolution in the ambulatory virtual care landscape, we have also witnessed marked disparities in how different populations of patients are accessing our institution's telemedicine care. Our institution has developed multiple

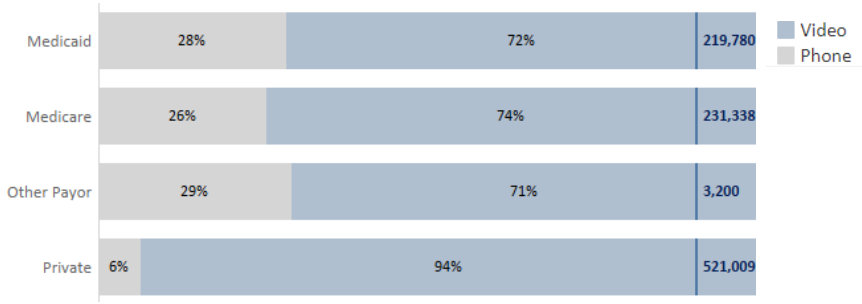


Note: Excludes "telemedicine insensitive" visits, such as lab, radiology.

dashboards to understand trends in telemedicine care including a telemedicine equity dashboard. We have focused on the percent of total telemedicine care that is delivered by telephone – instead of by video – as an initial disparity measure. When we look over the past 2 years, we see that percent of telemedicine encounters are more common among Medicaid-enrolled patients and Black/African American patients. But we are also seeing higher rate of telephone visits among patients who are publicly insured, are Black/African-American, are Spanish-speaking, are older, or who live in historically under- resourced neighborhoods in east and west Baltimore. For example, while 8% of encounters with privately- insured Maryland patients were conducted by telephone, 27% of encounter with Medicaid-insured Maryland patients were conducted by telephone. These data suggest to us

that audio-only covered should continue until significant investments can be made to make video-based telemedicine more accessible to all groups.

Video vs. Audio-Only (Phone) Visits by Payor Type:
July 2020 – Current (Maryland Only)



Lastly, synchronous telehealth visits represent real clinical time and investment. Frontline clinical care providers time with patients whether in person, by video, or by phone is equivalent, impactful care delivery – and the CMS 2021 final rule progression towards total time billing is reflective of the fact that all time spent on patient care should be viewed similarly. In addition, the cost of the visit is not only the provider's time, but also all of the pre-visit, post-visit, and between visit care and coordination – all of which is similar regardless of visit modality. Finally, health systems small and large are investing in the necessary additional resources to support patients (and providers) in education and training to optimally engage digitally, while also investing heavily to meet all of the evolving regulatory aspects of virtual care.
In light of each of these facts, we strongly support ongoing payment parity for both video and audio-only care, which will benefit patient access and choice, especially those covered by Maryland Medicaid.

Kennedy Krieger Institute
Submitted by Jen Crockett, Ph.D., BCBA-D, *Director, Behavioral Health Program for Military Families; Director, Telehealth*
What are the leading benefits, barriers, and challenges in using audio-video and audio-only technologies post-pandemic?
The two primary benefits of maintaining telehealth post-pandemic are 1) continued access to those in provider-shortage areas, particularly Eastern Shore, Southern Maryland, and Western Maryland and 2) the ability to provide services in patient's natural environment. Barriers remain, including engaging those who are hard to reach, either due to limited technology access, or limited

digital literacy. An identified challenge is maintaining the infrastructure necessary to ensure equitable access to telehealth as a service delivery model. This is particularly relevant if we do not have reimbursement parity.

Discuss patient outcomes (positive or negative) who received care using audio-video or audio-only technologies (empirical or anecdotal):

Kennedy Krieger Institute maintains an "Advancements in Telehealth" webpage that includes several of our published studies since the pandemic. In summary, we are finding high telehealth satisfaction across providers and patients, with consistent desire to have access to telehealth post-pandemic.

Any other information that you would like to share with MHCC:

Although Kennedy Krieger has found telehealth to be very useful within behavioral health care, we want to caution against considering telehealth just as a service delivery model for behavioral health care. We have had great success with other specialty services, including therapies and medicine. In our new and rapidly changing environment, patients and families have found the use of telehealth beneficial.

Licensed Clinical Professional Counselors of Maryland

Submitted by Angela Mazer through Robyn Elliott

Thank you for the opportunity to submit public comments on the use of telehealth in behavioral health care. I am Angela Mazer, and I've been a therapist for over 10 years. I am a clinical director at an outpatient mental health clinic. I am a member of Licensed Clinical Professional Counselors of Maryland, and I have written these comments on behalf of the organization. LCPCM is a professional organization that advocates for professional counselors and their clients, statewide.

I wanted to draw attention to the practical implications of protecting parity for telehealth rates and the audio option. We all should know that COVID has hit health care with a double whammy: increasing how many people need help and the ongoing shortage in the health care professional workforce. Maryland is behind other states. According to the Kaiser Family Foundation, Maryland only meets 22% of the need for mental health services in federally designated underserved areas.[1] This figure is startling, and does not reflect that many counties – even those who have more providers – are also struggling to meet the basic mental health needs of their residents.

Behavioral health care providers are struggling to maintain capacity to meet the needs of their clients. We can't find staff for community-based services because the salaries for reimbursement barely cover graduates' student loan debt. Maintaining reimbursement for behavioral health care, whether provided through in-person or telehealth, to ensure the stability of the behavioral health care system in this current crisis and long-term.

We have to meet clients where they are and telehealth is the bridge for those without transportation, those anxious about becoming infected, or dealing with major access issues. As far as audio services are concerned, it is critical to realize how my staff uses audio:

- We actually use audio as a back-up in the event that a telehealth client's Wi-Fi cuts out or they have another technical difficulty. With skyrocketing numbers of suicide, a technical glitch in the middle of session could mean life or death. We have all felt the frustration of a Wi-Fi or battery malfunction. The audio option is a steadfast back-up to finish a session.
- Some of our elderly or less technically literate folks use audio sessions to bridge the gap when transportation isn't possible or they can't afford the gas to come to see us. For those folks, telehealth platforms may be hard to navigate but a phone works wonders to check in about their symptoms or connect to their therapist.
- For individuals experiencing homelessness, Wi-Fi isn't a forgone conclusion, but a phone call is more manageable. We should never assume that transportation or Wi-Fi are privileges accessible to all Marylanders.
- Clients who experience domestic violence or other forms of abuse may not be able to come to a therapist's office, out of fear of their abuser, but an audio call can give them a private, secure lifeline to their therapist. This can literally save lives.

Thank you for your work on ensuring behavioral health care providers like myself can continue to serve our clients. Our behavioral health care system is at a precarious moment with the increase in demand for services and decreasing number of providers. It is critical that we can ensure that telehealth continues to be a viable communication option for behavioral health care professionals and clients.

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Maryland Community Health System (MCHS)

Submitted by Salliann Albourn through Robyn Elliott

Maryland Community Health System (MCHS) appreciates the opportunity to submit comments on the telehealth study being conducted by MHCC. Telehealth has become an essential component of health care services provided across the spectrum of practitioners.

Consumer-Centered Care: Strategy to Increase Consumer Engagement in Health Care

Telehealth is transformative because it places the consumer at the center of the health care system. Consumers can choose how to engage their providers, through telehealth or in-person services, just as long as the care being rendered is clinically appropriate. Consumers have demonstrated they want telehealth to continue as an option long-term. Telehealth was a necessity during the pandemic to reduce risk of COVID-19 transmission. It has now become an essential component of the health care delivery system to ensure providers can engage consumers in care who might not otherwise be able to access care.

As a network of federally qualified health centers (FQHCs), we focus on providing health care to the underserved who are often consumers with Medicaid, Medicare, or no insurance at all. This consumer community faces many challenges in accessing health care because of their economic, social and health circumstances. Consumers may lack access to reliable transportation, have mobility issues because of age or health issues, have little or no flexibility in taking off work for health care appointments, and generally have fewer resources to meet their health care needs.

As FQHCs, one of our challenges is connecting with consumers who have not had a history of engaging with the health care system. The Maryland Medical Assistance Program requires auto assignment of primary care providers if a Medicaid participant does not select a primary care provider. As a result, FQHCs are assigned a significant number of Medicaid participants who have not selected a primary care provider and have no or only minimal provider engagement.

During the pandemic, our FQHCs found that telehealth is an effective tool in engaging consumers who have no history of regularly visiting a provider. This was demonstrated in reductions in no-show rates for appointments. For example, one of our FQHCs experienced a two-thirds reduction in no show rates in a five-month period ending in July 2021 in comparison to the prior year. Our FQHCs experience is consistent with the peer-reviewed evidence. In a study on a telehealth initiative for pediatric patients in Chicago, telehealth visits caused no-show rates to decrease from 36% to 7.9%.[1] In a different type of setting, a network of adult and specialty clinics in Columbus, OH, the results were similar: The no-show rate for in-person visits was 36.1% vs. 7.5% for telehealth.[2]

No-show rates are an important indicator of whether consumers are receiving care to manage their health conditions. In an extensive retrospective analysis in Scotland, researchers concluded that “Missed appointments represent a significant risk marker for all-cause mortality, particularly in patients with mental health conditions.”[3] These research findings reflect the experience of our FQCHs. Consumers who miss appointments are less likely to receive prevention and chronic disease management services leading to more serious, debilitating, and costly health care needs later.

Value of Audio-Only Services

We wanted to highlight the FQHCs' experience with audio-only services, as we know that is of particular interest in MHCC's study. Our clinicians have found audio-only services to be critical in delivering care to people without access to reliable, broadband services, whether it is because they live in a rural community and/or cannot afford services. Audio-only telehealth services are very flexible and can be used to help patients manage chronic somatic care conditions or behavioral health care issues. While audio-only services have some limitations, audio-only services need to be maintained as they allow the provider to maintain a more regular provider-patient interaction and enable them to bring in the patient for in-person or audio-visual services if needed. Our FQHC members report that audio-only visits have remained critically important for a core of patients who do not have access to reliable broadband, even after the overall use of audio-only visits has shifted as more in-person visits have resumed.

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[3] McQueenie, R., Ellis, D.A., McConnachie, A. et al. Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Med 17, 2 (2019). https://doi.org/10.1186/s12916-018-1234-0

The Maryland Dental Action Coalition
Submitted by Robyn Elliott

Thank you for the opportunity to submit comments to the Maryland Health Care Commission on its telehealth study. The Maryland Dental Action Coalition supported HB 123/SB 3 in 2021, as the legislation included dental in the scope of authorized telehealth services under the Maryland Medical Assistance Program. As a result of the legislation and subsequent flexibilities provide under the federal public health emergency, Maryland dentists, particularly from community health centers, have begun to provide dental services through telehealth.

Dental Services that may be provided through telehealth include: 1) Examination post-op to monitor a patient's recovery from oral surgery; 2) Assessment in a dental emergency, as the dentist can assess the patient's condition and determine next steps; this is particular important for consumers that lack access to specialty care such as pediatric oral surgeons, in rural areas of the state; and 3) Prescription of antibiotics to treat tooth infections, as these infections can spread quickly and become systemic. A pilot study from Canada found that teledentistry can be effectively used to screen students for dental issues.[1]

Telehealth is also an important tool to support the dental health of pregnant patients and their children. MDH's best practice standards for dental health during pregnancy include a strong emphasis on collaboration between prenatal and dental providers, and the General Assembly recently passed legislation to allow dental hygienists to work in prenatal offices while still under the general supervision of a dentist.[2, 3] The use of telehealth will allow for closer coordination between prenatal providers, dentists and dental hygienists. This coordination will allow prenatal providers to bring dental screening and consultation into their offices, instead of just giving patients a referral. Making collaboration between dental and prenatal providers easier is essential because the American College of Obstetricians and Gynecologists (ACOG) reports that 40% of women experience some form of periodontal disease during pregnancy.[4]

Telehealth improves access to dental care for individuals who face challenges with mobility, reliable transportation, or difficult work and family care schedules. Telehealth also improves access to dental care in entire communities that have provider shortages. Maryland has 44 dental health professional shortage areas affecting access for almost 1.1 million Marylanders.[5] The provider shortage has a particular significant impact on people who need specialty care or who have special needs.

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The Maryland Nurses Association (MNA)

Submitted by Robyn Elliott

The Maryland Nurses Association (MNA) would like to offer these comments as the Maryland Health Care Commission studies the value of telehealth, as directed under House Bill 123/SB 3 of the 2021 session. Nurses were earlier adopters of telehealth communication platforms, initially in their role of case managers. The role of telehealth had already been growing when the COVID-19 began; and now telehealth has become an integral part of the health care system. The value of telehealth is significant, as demonstrated by the peer-reviewed research. Telehealth improves clinical outcomes, increases access to care, and supports practitioners who are stretched to capacity:

- Improved Clinical Outcomes for Chronic Disease Management and Acute Care: Telehealth is an effective strategy to improve clinical outcomes for a wide range of acuity from management of chronic diseases such as hypertension,[1] triaging

urgent care needs,[2] and managing post-acute care. Telehealth has also demonstrated to be effective in addressing health disparities, for example, one study found that telehealth increased ability of Black patients to attend post-hospitalization follow-up appointments;[3]

- Expands Access to Care: When telehealth was first implemented, the focus was largely on rural communities because of difficulty of accessing care within a reasonable distance. Telehealth remains an important strategy to improve access to rural health; but the experience of the pandemic has demonstrated its importance in improving access to care for a wider range of communities – including working families who face challenges in navigating work and family demands, people with mobility issues because of age or medical conditions, people without access to reliable transportation in urban and suburban areas, and people who have anxiety about connecting to the health care system;[4]
- Importance of Telehealth Platform Options: As we have seen with the pandemic, it is critical that we embrace a wide range of telehealth platform options – from audio-visual to audio-only technologies in order to meet the needs of clients. For example, it has been found that patients who were older than 65, Black, Hispanic, Spanish-speaking, and from areas with low broadband access were more likely to use audio telehealth over video.[5] Restrictions on audio-only care risks exacerbating health inequities by leaving patients from marginalized out of the benefits of telehealth;
- Supported Health Care Professionals: Health care professionals, particularly nurses, have been stretched beyond capacity because of the pandemic. A 2021 survey found that 90% of nurses leaving within 1 year if workload and patient flow issues were not addressed.[6] Telehealth has the ability to reduce staffing burdens by allowing certain administrative tasks to be automated and to allow providers to spend more of their time on providing care. A recent survey of providers also found that utilization of telehealth improves provider job satisfaction, which could help address growing health care staffing shortages.[7]

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Mid Atlantic Association of Community Health Centers (MACHC)

Submitted by Pamela Metz Kasemeyer, Esq., *Schwartz, Metz, Wise and Kauffman, P.A.*

MACHC and Maryland Health Center Overview: MACHC is the federally designated Primary Care Association for Maryland and Delaware Federally Qualified Health Centers (FQHCs). The seventeen Maryland community health centers collectively provide patient-centered primary care to more than 310,000 medically-underserved patients. Most patients are Medicaid beneficiaries (48%) or uninsured (17%). Our members are part of the national network of FQHCs providing affordable, high-quality, comprehensive primary care to 30 million individuals, regardless of their insurance status or ability to pay.

Telehealth in Maryland Health Centers

- Health center grantees are required to offer comprehensive services in areas of high need, including sparsely populated rural areas.
- Health centers have pioneered telehealth for many years to expand access to quality care in hard-to-reach areas.
- For the past two years, telehealth has served as an essential way to deliver needed health care to patients from the safety and comfort of home.
- As a provision of the COVID-19 Public Health Emergency, Medicare and Medicaid have allowed health centers to provide vital primary and preventive virtual care.
- These policy changes and rapid deployment of needed infrastructure have drastically expanded the scope of telehealth services that health centers offer.
- Telehealth has emerged as a vital force connecting patients to health centers. During the COVID-19 pandemic, telehealth was a lifeline that kept patients and care providers connected.
- Health center patients experience significant barriers that may make telehealth appointments easier to keep, like reliable transportation, childcare, or flexibility with work.
- Without telehealth, many patients may have to go without needed care, particularly in rural areas where public transportation is scarce.
- Audio-only telehealth has been essential in reaching patients who have limited broadband access or who live in rural areas. Permanently codifying audio-only telehealth will allow Maryland health centers to continue to reach the state's most vulnerable patients.

- Ensuring health center patients have continued access to primary and preventive virtual care is essential to improving Maryland's population health and health equity.

Maryland Health Center Telehealth Numbers for 2020. 2021 data will be provided when analysis is completed which is estimated to be later this summer.

- In 2020, 25% of medical and 43% of behavioral health care appointments were telehealth.
- Telehealth also helped connect patients with services beyond just medical care – 32% of appointments with case managers took place via telehealth.
- All seventeen Maryland health centers utilized telehealth in some capacity during 2020.
- Telehealth services helped patients access a wide range of care but were primarily used for primary care, mental health, substance use disorder, and chronic disease appointments.

Mt. Washington Pediatric Hospital

Submitted by Dr. Bradley Schwimmer

1. **What are the leading benefits, barriers, and challenges in using audio-video and audio-only technologies post-pandemic?**

The main benefit is access. In terms of audio only, some patients do not have access to sufficient streaming, so using video is untenable. Audio allows improved access. I do think audio and video is ideal, as the video does provide you with the facial and context cues. However, if the option is audio or no session, audio is clearly preferable.

2. **How have you navigated privacy issues with the implementation or expansion of telehealth services?**

I make sure that each patient is a private area, and sometimes I even have patients give me a “virtual tour” of the space there are in. I have not seen this to be an issue so far. Some older patients have been able to go to a library and use a room there. Others have found rooms in the school buildings. Being creative has helped!

3. **Discuss patient outcomes (positive or negative) who received care using audio-video or audio-only technologies (empirical or anecdotal).**

The outcomes are endless. Parents have reported on improved behavioral functioning of their children. Patients have seen more steady progress due to reduction of missed sessions due to transportation issues and other access issues. Parents have loved the ease of accessibility and teenagers love doing virtual therapy as they are used to virtual socializing.

Tri-State Community Health Center (TSCHC)

Submitted by Susan B. Walter, MSW, *Chief Executive Officer*

TriState Community Health Center is a FQHC providing comprehensive quality health care for 20,000 rural patients at 5 sites: Hancock, MD; 2 Cumberland, MD, sites – one is an OB/GYN Women's Health Center; McConnellsburg, PA; and Berkeley Springs, WV. TSCHC was incorporated in Hancock 35 years ago to provide quality care to everyone regardless of income residing in our expansive geographic region with adjoining MD, PA, and WV boarders.

I am grateful to the MHCC for holding Telehealth Town Halls. Tri-State Community Health Center (TSCHC) is unable to be present, so I am writing you to provide a voice for our rural patients. Tri-State Community Health Center is a FQHC providing comprehensive quality health care for 20,000 rural patients at 5 sites: Hancock, MD; 2 Cumberland, MD, sites – one is an OB/GYN Women's Health Center; McConnellsburg, PA; and Berkeley Springs, WV. TSCHC was incorporated in Hancock 35 years ago to provide quality care to everyone regardless of income residing in our expansive geographic region with adjoining MD, PA, and WV boarders.

Please forward to MHCC and incorporate in their recommendations our brief requests which are critical for the continuity of TSCHC's quality patient care:

There must be state reciprocity in telehealth. Telehealth is bound by state boarders which have nothing to do with provision of needed heath care to patients from multiple states. If a provider is not licensed in a state where a patient resides then they will not be able to have a telehealth appointment for that patient. Our providers are duly licensed in the state of the site where they provide care, but few have licenses in all three states. MD, PA, and WV patients are seen at each of TSCHC's sites because people do not pay attention to or care about state boarders in seeking health care, shopping, etc.

Audio/telephone visits must be included in telehealth and must be fully reimbursed as a legitimate visit. Experience and common sense informs us that many of our rural - especially our elderly – patients cannot afford computers, don't have internet accessibility, are uncomfortable with the technology. These patients are comfortable with telephones and are accustomed to talking with TSCHC staff by phone for 35 years. Telephone telehealth has been very successful with TSCHC's patients and has overcome the pressing transportation challenges of many in TSCHC's mountainous rural region especially treacherous in inclement weather. If telephone telehealth is not permitted, TSCHC will lose the close contact we have developed with many of our patients - many with complex chronic conditions.

Telehealth visits must be duly reimbursed for all forms of telehealth.

University of Maryland Medical System (UMMS)

Submitted by Heather A. Beauchamp, MSN, RN, LSSBB, *Director of Telehealth Program Development*

1. **What are the leading benefits, barriers, and challenges in using audio-video and audio-only technologies post-pandemic?**
    - A benefit of telehealth, for both audio-only and audio- video, is the ability to see patients in place. There is no distribution to their workday and telehealth overcomes barriers many face related to transportation. Both forms of

telehealth increase continuity of care, allows patients greater access to providers, and assists in addressing health care disparities.

- Audio only is an important backup for those that are challenged with the audio-video and for those that may reside in an internet desert.
- Patients provide positive feedback regarding telehealth services. The data below is from Press Ganey, Primary Care Only, for the last rolling year. (The column on the far right is the total number of respondents)

Questions	Average Response	
Care providers discussion of any proposed treatment	4.8	910.0
Care providers efforts to include you in decisions about your care	4.8	913.0
Concern the care provider showed for your questions or worries	4.8	936.0
Ease of arranging your video visit	4.7	946.0
Ease of contacting (e.g., email, phone, web portal) us	4.6	912.0
Ease of talking with the care provider over the video connection	4.7	708.0
Explanations the care provider gave you about your problem or condition	4.8	917.0
How well the audio connection worked during your video visit	4.7	700.0
How well the video connection worked during your video visit	4.7	583.0
How well the video visit staff (including the care provider) worked together to care for you	4.8	872.0
Likelihood of your recommending our video visit service to others	4.8	898.0
Likelihood of your recommending this care provider to others	4.8	915.0

2. **How have you navigated privacy issues with the implementation or expansion of telehealth services?**

Providers are instructed to verify patients are in a private area or if they are in the presence of others the provider is to verify that the others may hear the patients' health care information. The providers are also educated to consent the patient at the start of each visit.

3. **Discuss patient outcomes (positive or negative) who received care using audio-video or audio-only technologies (empirical or anecdotal).**

UMMS has seen many benefits of telehealth.

- One that stands out is the ability to continue to provide care to patients within their community, a true patient satisfier. A specific example of this is the use of audio-video telehealth on the Eastern Shore for patients who have had a stroke. Previous to telehealth, patients would be transferred to Baltimore for services. Now with audio-video telehealth some stroke patients stay at their community hospital under the remote care of a neurology team.
- Telehealth allowed UMMS to expand intensive care beds at the downtown campus during Covid surges.
- Telehealth (eConsults) decreases unnecessary transfers across the system, which frees up beds for patients that require them, decreases delays in care, and unnecessary ambulance use.

- Teletriage in the Emergency Department has accelerated care for many patients. Obstetrical patients are a population that has benefited. When a pregnant patient registers in the Emergency Department the patient can be teletriaged quickly and the patient can be connected to the appropriate service, obstetrics, rather than waiting to be seen in person by an Emergency Medicine (EM) Physician. Teletriage expedites care for other patients as well. The teletriage EM provider will place orders for necessary imaging and lab studies. When the patient then sees the in-person EM provider many of these diagnostic studies are complete, expediting the process.

4. Any other information that you would like to share with MHCC.

UMMS sees telehealth, audio-video and audio-only, as a necessary tool to provide our inpatients and outpatients improved access to care, continuity of care, and address health care disparities.